

APPENDIX 5

THE PATIENT SAFETY CULTURE SURVEY

Statewide Results

August 2014



75%

Fear of Punitive Response

5,000+

Institution Health Care Staff Participated in
the Patient Safety Culture Survey

70%

Did Not Report any Health Care
Events in the last 12 Months

Background

PATIENT SAFETY CULTURE IN HEALTH CARE

There is a subset of industries, such as commercial aviation, nuclear power, and national defense, in which process failures can lead to catastrophic consequences. With high stakes to get things right, some organizations within these industries have been able to achieve exceptionally high levels of reliability in their systems and processes and have become known as High Reliability Organizations. In the past decade, health care leaders and policymakers have studied High Reliability Organizations to learn how their practices and philosophies might help improve health care processes. They learned that High Reliability Organizations avoid plane crashes, nuclear meltdowns, and accidental death by identifying weak danger signals and responding to them strongly, so system functioning can be maintained and disasters avoided.¹ But early warning systems only thrive in a certain type of organizational culture: one that supports safety, learning, and improvement.

The Joint Commission, a highly respected accrediting entity for health care systems in the United States, requires organizations to establish a culture of safety as part of their minimum accreditation standards. To date, more than 20,000 health care organizations are subject to this requirement. Why does the Joint Commission consider a patient safety culture so important?

“An organization’s culture reflects the beliefs, attitudes, and priorities of its members, and it influences the effectiveness of performance. In a culture of safety and quality, all individuals are focused on maintaining excellence in performance... In a culture of this kind, one finds teamwork, open discussions about safety and quality, and the encouragement and reward for internal and external reporting of safety and quality issues.”²

While cultural values in the correctional health care work environment may seem nebulous, the impact on performance is real and can be experienced in tangible ways – actual harm to patients, frustrating work environments, litigation, and a waste of time and resources.

A way to measure the impact of a safe culture is to examine what happens when that culture is *not* in place. In the absence of a patient safety culture, this type of adverse patient health care event occurs not infrequently:

When a laboratory technician arrives in the morning, he checks the office voicemail and finds a message left by the reference

BY THE NUMBERS

(See Appendix 1 for more information about this data.)

384 (14%) CDCR inmate deaths between 2006 and 2012 were likely or possibly preventable.

Medical errors are the eighth-leading cause of death in the United States each year.

2,300 (31%) CCHCS hospitalizations in 2013 were potentially avoidable, totaling over **\$44 Million**.

In 2009, over 600,000 hospitalizations (26%) of U.S. Medicare and Medicaid patients were potentially avoidable, totaling \$5.4 billion.

34,000 (45%) CCHCS patients did not receive their medications timely in April 2014.

In the United States, 5 medication errors occur per 100 medication administrations.

8,456 (42%) CCHCS patients on high risk psychotropic medications in July 2014 had one or more overdue diagnostic monitoring laboratory test – totaling **20,646** overdue tests.

¹ *Transforming Hospitals into High Reliability Organizations: Becoming a High Reliability Organization: Operational Advice for Hospital Leaders*. April 2008. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/hroadadvice1.html>

² Introduction to Organization Culture and System Performance Expectations, Standards LD 03.01.01 through LD.03.06.01, The Joint Commission

laboratory over the weekend, notifying the institution that a patient has dangerously abnormal lab results.

The lab technician contacts the primary care clinic to convey the results, and learns that the patient had to be hospitalized over the weekend. He suspects that this type of event should be reported through the Health Care Incident Reporting System, but decides not to report because the last time a report was submitted four nurses and two physicians were referred for investigation and discipline.

Six months later, another critical lab result for another patient is left on the voicemail over the weekend, and this time the patient dies.



Modifying our health care delivery system around the edges with fragmented corrective actions will not get to the core of our quality problems. The literature is clear – for sustainable high value care and a high quality work force, health care organizations need to address culture.

A PATIENT SAFETY CULTURE IN CALIFORNIA PRISONS

Policy requires Leadership to take action to promote a Safety Culture.

At the end of 2012, California Correctional Health Care Services (CCHCS) and the Division of Health Care Services (DHCS) established a statewide Patient Safety Program, which is committed to promoting a culture of learning and safety. Per current policy, our overarching goal is to prevent harm to patients and staff by ensuring a healthy work environment that promotes communication, teamwork, staff support and supervision, and an effective non-punitive system to report, understand, and fix safety problems.

CCHCS and DHCS (Health Care Services) spent most of 2013 ramping up the statewide Patient Safety Committee, and implementing a statewide Health Incident Reporting System and Root Cause Analysis process. At the beginning of 2014, our organization turned its focus to obtaining a baseline measurement of our current organizational culture. What are our strengths and weaknesses? How far are we from our vision of a patient safety culture? The baseline assessment also served to raise awareness about the new Patient Safety Program and the many factors that increase or decrease risk to patients and staff.

ASSESSING CULTURE – THE PATIENT SAFETY CULTURE SURVEY

To conduct its baseline assessment, Health Care Services elected to use a nationally accepted survey tool designed by the federal Agency for Healthcare Research and Quality (AHRQ), which both establishes a standardized methodology for measurement and allows organizations to compare their results with other health care organizations across the country. See Appendix 2 for detailed specifications and explanations about this survey.

The AHRQ survey tool asks 44 core questions that measure *ten dimensions* of patient safety and *four overall patient safety outcomes*. The major survey categories are described below.

Dimensions of Patient Safety

1	NON-PUNITIVE RESPONSE TO ERRORS Staff do not feel their mistakes are held against them or kept in their personnel file, and they are not afraid to report when an event occurs.
2	FEEDBACK & COMMUNICATION ABOUT ERRORS Staff are informed when errors occur, discuss ways to prevent them from happening again, and are given feedback when changes are made as a result of reported errors.
3	COMMUNICATION OPENNESS Staff are not afraid to speak up if they see something that may negatively affect patient care or will ask questions if something does not seem right.
4	HANDOFFS & TRANSITIONS Patient care is coordinated well during shift changes or patient transfers.
5	TEAMWORK ACROSS UNITS Units across the institution coordinate and cooperate well together to provide care for patients, which includes the exchange of pertinent patient information.
6	TEAMWORK WITHIN UNITS Members within each unit support and respect each other, and work well together to provide care for patients.
7	ORGANIZATIONAL LEARNING-CONTINUOUS IMPROVEMENT Staff are actively doing things to improve patient safety and sustain progress.
8	FACILITY MANAGEMENT SUPPORT FOR PATIENT SAFETY The actions of management show that patient safety is a top priority.
9	STAFFING Staff are able to handle the workload without working longer hours or using more temporary staff than recommended.
10	SUPERVISOR/MANAGER EXPECTATIONS & ACTIONS PROMOTING PATIENT SAFETY Management staff are supportive, do not overlook recurring patient safety problems, and seriously considers staff suggestions for improving patient safety.

Patient Safety Outcomes

A	OVERALL PERCEPTIONS OF SAFETY Patient safety is not sacrificed to get work done, and procedures/systems prevent errors from happening.
B	FREQUENCY OF EVENTS REPORTED Mistakes are reported most or all of the time.
C	EVENTS REPORTED Staff have reported one or more events within the last 12 months.
D	OVERALL PATIENT SAFETY GRADE Staff who gave their institution an overall Patient Safety grade of "very good" or "excellent".

Findings

SURVEY RESPONSE RATE

The Patient Safety Culture Survey project was an intensive, collaborative effort across the organization, which included weekly activities, a customized marketing program for each facility and ongoing technical support. Over the course of a three-week period in February and March 2014, all institution health care staff statewide were invited to participate in the survey, including correctional officers, administrative and analytical staff, and other staff who indirectly support patient care. In order to present survey results that most likely express the opinions of all staff, a statistically representative sample size was necessary. Generally, response rates for surveys vary widely from 19% to 70%³. Health Care Services set the following statewide response rate goal:

Health Care Services will achieve at least a 50% survey participation rate statewide.

- Over 5,400 healthcare staff (53%) from all 34 CDCR institutions across the state completed the 2014 Patient Safety Culture Survey, exceeding the goal on our first statewide survey effort! (Table 1)



Table 1: Statewide Survey Response Rate by Institution Staffing Category
February 2014

Staffing Category*	Number of Staff who Responded to the Survey	Total Filled Positions**	Percent of Staff who Responded to the Survey
Clinical Support	192	344	56%
Administrative (includes HCAU Custody staff)	1,885	2,320	81%
Dental	395	794	50%
Mental Health	644	1,363	47%
Pharmacy	272	425	64%
Medical	174	378	46%
Nursing	1,884	4,729	40%
Total	5,446	10,354	53%

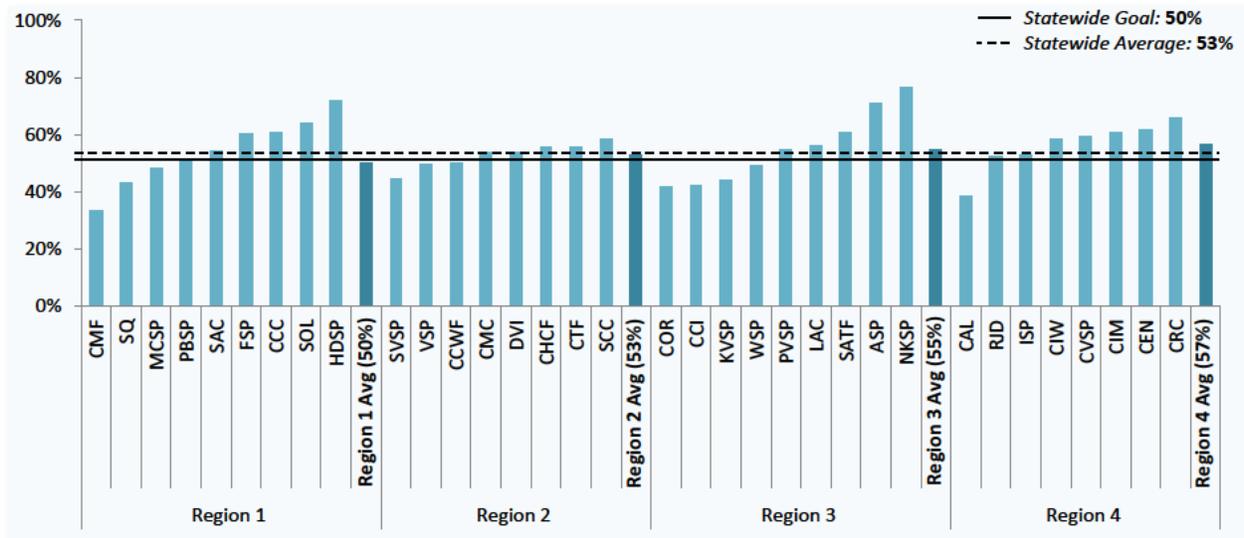
* Classifications of respondents include: Admin/Clerical/Support, Clinical Social Worker, Custody, Dental Assistant, Dental Hygienist, Dentist, Dietician, Food Administrator/Cook, Health Records Technician, Information Technology Staff, Laboratory Assistant, Laboratory Technician, Licensed Vocational Nurse, Manager/Supervisor, Nurse Practitioner, Pharmacist, Pharmacy Technician, Public Health Nurse, Physician & Surgeon, Physician Assistant, Psych Technician, Psychiatrist, Psychologist, Radiology Technician, Recreational Therapist, Registered Nurse, Specialty Provider, Supervising Registered Nurse II

** Staffing totals are reported for April 2014 and exclude headquarters positions.

³ Yun, Trumbo. Comparative Response to a Survey Executed by Post, E-mail, & Web Form. Journal of Computer-Mediated Communication. 2000;6(1).

- Three institutions (NKSP, HDSP and ASP) exceeded the statewide goal by a large margin, obtaining response rates over 70%. (Chart 1)

Chart 1: Statewide Survey Response Rate by Region and Institution
February 2014



SURVEY RESULTS

How We Compare To Other Health Care Organizations

Health care organizations nationwide that use the same AHRQ survey face many of the same challenges we do, according to comparative data (Table 2). For example, our statewide survey results indicate that we struggle with Non-Punitive Response to Errors and Handoffs & Transitions, which are also the lowest-scoring major categories for other health care organizations across the United States. Our areas of strength are the same as well – Teamwork Within Units and Supervisor/Manager Expectations & Actions Promoting Patient Safety.

In general, Health Care Services' performance lags behind other health care organizations nationwide. Our overall score for all ten Dimensions of Patient Safety categories is more than ten percentage points lower than the national average. In some categories, the difference between our scores and those of other health care organizations is particularly striking: *we are almost twenty percentage points below other participating organizations in believing that there will not be punitive actions if we report errors, and not surprisingly staff are less likely to report errors compared to other health care organizations (Table 2 results shown in red).*

**Table 2: Health Care Services Performance in Patient Safety Culture Survey
Categories Compared to Other Health Care Organizations Nationwide**

Data Sources: 2014 AHRQ Comparative Database and 2014 Health Care Services Survey Results

Dimensions of Patient Safety		AHRQ Results Govt	AHRQ Results Non-Govt	Health Care Svcs
<i>Number of Participating Facilities</i>		140	513	34
<i>Response Rate</i>		54%	54%	53%
1	Non-Punitive Response to Errors	43%	45%	25%
2	Feedback & Communication About Errors	66%	67%	51%
3	Communication Openness	61%	63%	58%
4	Handoffs & Transitions	50%	47%	43%
5	Teamwork Across Units	61%	60%	52%
6	Teamwork Within Units	79%	81%	72%
7	Organizational Learning-Continuous Improvement	72%	73%	59%
8	Facility Management Support for Patient Safety	74%	72%	57%
9	Staffing	54%	56%	48%
10	Supervisor/Manager Expectations & Actions Promoting Patient Safety	75%	76%	66%
<i>Overall Score – 10 Dimensions of Patient Safety</i>		64%	64%	52%
Patient Safety Outcomes		AHRQ Results Govt	AHRQ Results Non-Govt	Health Care Svcs
A	Overall Perceptions of Safety	66%	66%	54%
B	Frequency of Events Reported	66%	66%	58%
C	Staff Reported One or More Events in 12 Months	37%	45%	30%
D	Overall Patient Safety Grade	76%	76%	62%

Statewide Findings

Health Care Services has set statewide goals relative to patient safety culture.

By December 31, 2016⁴, each institution will:

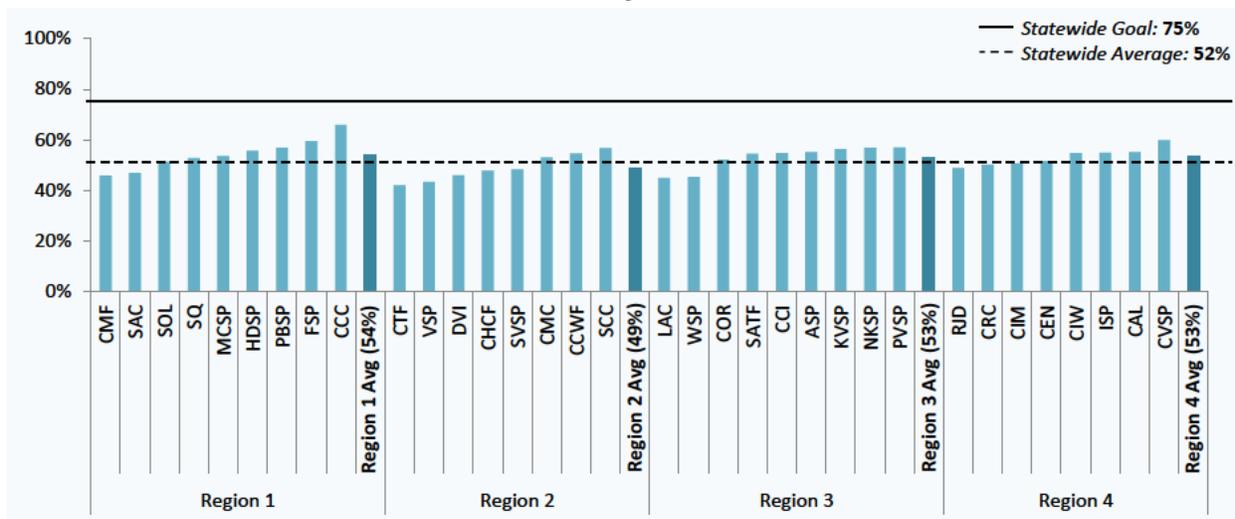
- ★ Achieve an average of 75% or more in the Patient Safety Culture Survey overall score and in each of the 10 major dimensions and 4 patient safety outcomes, or at least a 20% increase from baseline results.
- ★ Achieve an average of 75% or more, or at least a 20% increase from baseline results, for the following measures: Non-Punitive Response to Errors and Staff Reported One or More Events in 12 Months.

In our findings, survey results are compared to the statewide performance objective and the performance of other health care organizations in the United States.

- Our baseline overall score statewide was 52%, which is below the national average of 64% and twenty-three percentage points below the statewide goal. (Table 2)
- Region I had the highest overall regional survey score at 54%. (Chart 2)
- No institution met the statewide goal of 75% for overall score in this baseline survey and all institutions rated below the national average with the exception of CCC at 66%. (Chart 2)

Chart 2: Overall Scores by Region and Institution

February 2014



- The organization has the most room for improvement statewide in the areas of Non-Punitive Response to Errors and Events Reported. (Appendix 3)
- Survey results show that a large proportion of staff (75%) believes their mistakes will be held against them and only 30% of staff have reported a health care event in the last 12 months. Though national scores were lowest in these areas as well, our organization's results were even worse.
- 48% of staff reported a lack of coordination among care teams within their institution and across the system, and 57% of staff also reported having problems with handoffs and patient transfers.

A link to detailed institution and regional level reports is provided in Appendix 4.

⁴ Statewide performance objectives in this report have a target date that allows the organization a period of time for improvement activities before re-evaluation in approximately 12-18 months, at which time results will be available in 2016.

Recommendations

MAKING IT SAFE TO REPORT ERRORS

“The problem is seldom the fault of an individual; it is the fault of the system. Change the people without changing the system and the problems will continue.”

Don Norman
Author, *Design of Everyday Things*

In a thriving patient safety culture, staff are comfortable reporting actual adverse events and near misses so that systems and organizational issues can be identified and corrected. Research shows that systems failures are the root cause of most patient safety incidents, but when an adverse event occurs, it is still the most common and immediate response at many health care organizations to initiate a disciplinary investigation instead of identifying system factors that may have caused or contributed to the event. As a result, employees are often afraid to report a patient safety incident for fear of punishment or retaliation from their supervisors or colleagues. The first step in the organization’s effort to decrease fear of reporting adverse health care events is to establish standardized guidance that is focused on understanding system and process breakdowns and fixing them, and appropriate accountability for reckless behavior or blameworthy acts.

Standardized Decision Algorithm. The statewide Patient Safety Committee has formed a workgroup tasked with developing a decision algorithm to help institution executives, managers and supervisors apply a standardized set of questions when a health care incident is reported. The algorithm focuses on an individual’s actions, motives and behavior at the time of the incident/error in order to determine the most appropriate course of action. To ensure that the decision algorithm is accepted and supported by key stakeholders, this workgroup is made up of representatives from across the organization including all clinical disciplines, Institution Chief Executive Officers, legal, labor relations, policy, custody and more. This tool is expected to be released in 2015.

CHALLENGING HEALTH CARE LEADERS TO WALK THE TALK

Culture change begins at the highest echelons of the organization and requires leaders to support patient safety by actively demonstrating their commitment to making positive change. The progress and momentum of culture change does not stop when executives leave a meeting; supporting the continual evolution of a changing culture is part of a leader’s daily work and should be evident in all areas of the organization – from clinics to administrative offices to each individual staff member and patient.



Health Care Services executives at headquarters are committed to being catalysts for change at the enterprise level by taking actions that foster a culture dedicated to building a safe and reliable system for delivering health care. Examples of actions include:

- Discuss the Patient Safety Culture Survey Report and major findings with leadership at the Department of Adult Institutions (DAI) to garner support for a decision algorithm that expands the organization's response to errors/adverse events to include alternatives such as root cause analysis and process redesign; and takes appropriate action for blameworthy acts.
 - In this discussion, consider the many paths in which adverse events are currently addressed in our system, including Office of Internal Affairs investigations, professional practice peer review, program or litigation specific corrective action plans, and root cause analysis.
- Provide recommendations to the Health Care Services Human Resources department as they begin the process of evaluating and modifying the Employee Disciplinary Matrix.
- Share the Patient Safety Culture Survey Report with external stakeholders such as Unions.

Regional team members and institution managers and supervisors can set the example by reporting patient harm, studying and understanding fundamental system problems, implementing solutions to prevent reoccurrence, and sharing errors and improvements with line staff. There are a number of activities that leaders can do *now* to demonstrate that they are invested in providing safe care to patients and a safe work environment for staff, the following are a few examples:

- **Chief Executive Officers, Institution Managers and Supervisors** – When notified of a health care incident, ensure that a Sentinel Event Adverse Event Reporting Form is completed and submitted to headquarters within 24 hours of the incident. [Click here to access Patient Safety on Lifeline for forms and more information.](#) The Adverse/Sentinel Event Review Executives and Regional Administrator will be in contact and will provide guidance on how to address the event within one week (and sometimes as quickly as 24 hours).
- **Physician and Nursing Leaders** – When patients are sent to the hospital for urgent/emergent care, reflect on whether or not the event is reportable and submit a report if appropriate.
- **Chief Nurse Executives and Supervising Registered Nurses** – While reviewing monthly Medication Administration Process Improvement Program (MAPIP) audit findings, identify and report medication events such as missed or delayed delivery of medications.
- **Chief Executive Officers** – Establish a local Patient Safety Committee to review reported events, identify local trends and areas for improvement, test and apply interventions that prevent harm, and identify local Patient Safety and Root Cause Analysis (RCA) champions.
- **Institution Quality Management Committee** – Include patient safety issues, such as medication errors, avoidable hospitalizations, and timely availability of health information when setting priorities in the Institution Performance Improvement Work Plan (PIWP).

- **Local Committee Chairs and Quality Management Support Unit (QMSU) Staff** – Include patient safety as a standing agenda item for all quality committees to discuss patient safety issues and adverse health care events that impact their respective business areas or programs. Provide training to institution staff in each discipline and business area about how to access the Health Incident Reporting System and statewide requirements for reporting.
- **Regional Administrators, Chief Executive Officers and Institution Leaders** – Actively promote the importance of patient safety and reporting of health care events through various communication channels and forums, and congratulate staff when they do report.
 - Some institutions have given awards and used other creative methods to give commendations to staff for reporting health care events.
- **Institution Leadership Rounds** – Convene a team of managers and clinical staff who make regular visits to areas of the facility where care is being provided to discuss health care events that have been reported, potential risks to patients in different care settings, recent RCAs, patient safety stories and alerts, improvement strategies resulting from Patient Safety Culture Survey findings, and other patient safety initiatives being implemented locally.

Appendix 1

By the Numbers	Additional Information
384 (14%) CDCR inmate deaths between 2006 and 2012 were likely or possibly preventable.	<p>Of 2,758 inmate deaths between 2006 and 2012, 384 deaths (14%) were identified as likely or possibly preventable.</p> <p><i>Source: Analysis of 2012 Inmate Death Reviews in the California Prison Healthcare System</i></p> <p><i>Table 11. Rates of preventable deaths among California inmates, 2006-2012.</i></p>
Medical errors are the eighth-leading cause of death in the United States each year.	<p><i>Source: www.nursingcenter.com/ajnmedsafety</i></p> <p><i>Executive Summary – The State of Science on Safe Medication Administration Symposium</i></p> <p><i>Institute of Medicine, editor. To err is human: building a safer health system. Washington, DC: National Academies Press; 2000.</i></p>
2,300 (31%) CCHCS hospitalizations in 2013 were potentially avoidable, totaling over \$44 Million.	<p>Of 7,333 hospitalizations in 2013, 2,296 (31%) were identified as potentially avoidable (includes 30-day hospital readmissions).</p> <p>In 2013, hospitalization costs totaled over \$141 Million and 31% (or \$44 Million) of that cost was identified as potentially avoidable (includes 30-day hospital readmissions).</p> <p><i>Source: Third Party Administrator Claims for all hospitalizations during 2013.</i></p>
In 2009, over 600,000 hospitalizations (26%) of U.S. Medicare and Medicaid patients were potentially avoidable, totaling \$5.4 billion.	<p>Among the almost 2.3 million hospitalizations for MMEs in 2009, over 600,000 (or 26 percent) were considered potentially avoidable, with an average cost of \$8,783. The overall Medicare and Medicaid costs for these potentially avoidable hospitalizations were \$5.4 billion, with the Medicare program bearing 96 percent of the costs.</p> <p><i>Source: Medicare-Medicaid Eligible Beneficiaries and Potentially Avoidable Hospitalizations</i></p> <p><i>Medicare & Medicaid Research Review 2014, Volume 4, Number 1.</i></p>
34,000 (45%) CCHCS patients did not receive their medications timely in April 2014.	<p>Of 75,500 patients who were prescribed medications in April 2014, approximately 34,000 (45%) did not receive their medications timely.</p> <p><i>Source: April 2014 Statewide MAPIP validation findings showing 55% compliance with timely medication administration.</i></p>
In the United States, 5 medication errors occur per 100 medication administrations.	<p><i>Source: www.nursingcenter.com/ajnmedsafety</i></p> <p><i>Executive Summary – The State of Science on Safe Medication Administration Symposium</i></p> <p><i>Bates DW, et al. Relationship between medication errors and adverse drug events. J Gen Intern Med. 1995; 10 (4):199-205.</i></p>
8,456 (42%) CCHCS patients on high risk psychotropic medications in July 2014 had one or more overdue diagnostic monitoring laboratory test – totaling 20,646 overdue tests.	<p>Of 20,026 patients on high risk psychotropic medications in July 2014, 8,456 (42%) patients had one or more overdue diagnostic monitoring laboratory tests.</p> <p><i>Source: July 2014 Dashboard raw data.</i></p>

Appendix 2

METHODOLOGY: PATIENT SAFETY CULTURE SURVEY

Source – The CCHCS Patient Safety Survey is based on the Agency for Healthcare Research and Quality, Hospital Survey on Patient Safety Culture.

Sorra JS, Nieva VF. Hospital Survey on Patient Safety Culture. (Prepared by Westat, under Contract No. 290-96-0004). AHRQ Publication No. 04-0041. Rockville, MD: Agency for Healthcare Research and Quality. September 2004.

Availability – The Survey was made available to over 10,000 healthcare staff across all 34 CDCR adult institutions between February 17, 2014, and March 7, 2014. Survey data was collected through Survey Monkey, a web-based surveying tool.

Confidentiality – The Survey was implemented in a manner which allows all respondent identifiers to remain confidential.

Survey Questions – The Survey consisted of 8 demographic questions about the respondent’s work location and professional background to allow for analysis by institution and discipline, and 44 core questions directly related to the 14 major categories of the patient safety survey:

- Non-Punitive Response to Errors
- Feedback and Communication about Errors
- Communication Openness
- Handoffs and Transitions
- Teamwork Across Units
- Teamwork Within Units
- Organizational Learning-Continuous Improvement
- Facility Management Support for Patient Safety
- Staffing
- Supervisor/Manager Expectations and Actions Promoting Patient Safety
- Overall Perceptions of Safety
- Frequency of Events Reported
- Events Reported
- Overall Patient Safety Grade

Opting Out of Questions – Participants were able to skip a survey question if desired.

Likert Scale – Core questions were asked using a Likert scale that offered 5 possible choices.

Reverse Logic Questions – A number of questions were worded using a reverse logic where “Strongly Disagree” or “Disagree” was a favorable answer. These specific question numbers are noted in the Institution Reports in red text and with a (®) symbol.

Reportable Data – To ensure confidentiality of staff in smaller units, survey results are only reported for questions with five or more responses.

Institution Results – Institution results by measure are calculated using only records where there is an actual response. Blank records are excluded.

Composite Results – Composite results across disciplines, institutions, and regions show un-weighted averages.

Appendix 3

		Nonpunitive Response to Errors	One or More Events Reported in 12 Months
	Statewide	25%	30%
Region 1	CCC	39%	29%
	CMF	20%	38%
	FSP	29%	20%
	HDSP	21%	30%
	MCSP	31%	16%
	PBSP	24%	30%
	SAC	23%	25%
	SOL	22%	20%
	SQ	25%	33%
Region 2	CCWF	26%	31%
	CHCF	23%	50%
	CMC	27%	41%
	CTF	23%	30%
	DVI	20%	35%
	SCC	23%	15%
	SVSP	25%	35%
	VSP	20%	27%
Region 3	ASP	27%	19%
	CCI	27%	29%
	COR	19%	39%
	KVSP	29%	27%
	LAC	20%	30%
	NKSP	28%	26%
	PVSP	26%	24%
	SATF	25%	33%
	WSP	18%	25%
Region 4	CAL	25%	37%
	CEN	20%	33%
	CIM	20%	41%
	CIW	25%	41%
	CRC	21%	23%
	CVSP	34%	22%
	ISP	34%	32%
	RJD	17%	42%

Appendix 4

DETAILED REPORTS

Detailed reports showing statewide, regional, and institution-specific results are available by clicking on the following link:

PATIENT SAFETY CULTURE SURVEY
2014 *Detailed Reports*