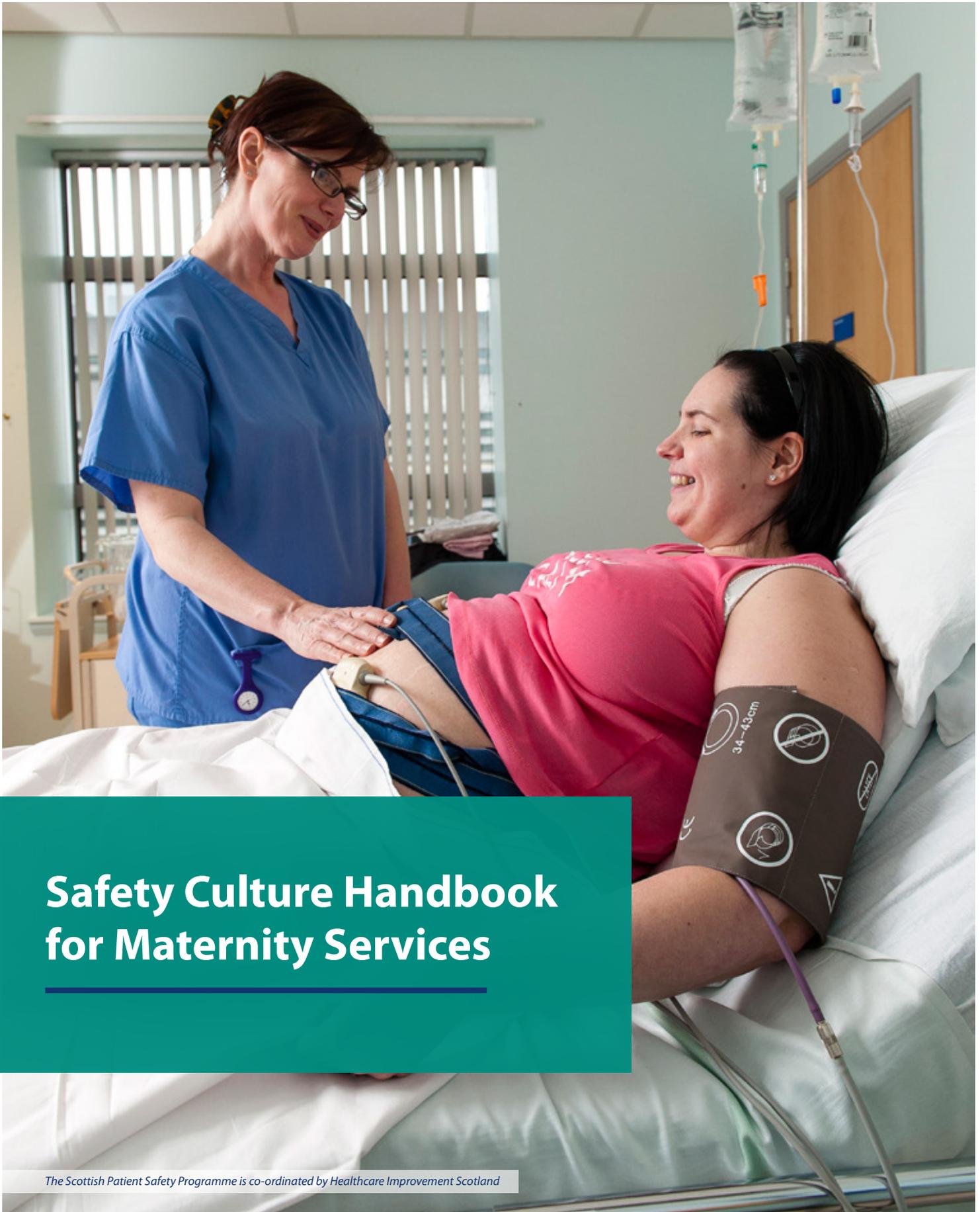




SCOTTISH  
PATIENT  
SAFETY  
PROGRAMME

MATERNITY  
CARE



# Safety Culture Handbook for Maternity Services

*The Scottish Patient Safety Programme is co-ordinated by Healthcare Improvement Scotland*

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**[www.scottishpatientsafetyprogramme.scot.nhs.uk](http://www.scottishpatientsafetyprogramme.scot.nhs.uk)**

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# Introduction

This Safety Culture Handbook for Maternity Services has been designed to support NHS board maternity services to:

1. **understand the importance of safety culture**
2. **undertake a patient safety climate survey**
3. **understand what the survey results are telling them, and**
4. **develop an improvement plan to address areas that have been highlighted.**

It is envisaged that this handbook will be used by the project team responsible for rolling out the survey, with support from hospital management.

This handbook has been developed with information from:

- the Hospital Survey on Patient Safety Culture User Guide prepared by the Agency for Healthcare Research and Quality<sup>1</sup>
- expertise of members of the Safety Culture Short Life Working Group, and
- the learning from the two safety culture pilot sites in NHS Greater Glasgow and Clyde and NHS Lothian.

A list of key definitions is provided in the glossary (Appendix A). Membership of the Safety Culture Short Life Working Group is provided in Appendix B.

This handbook includes copies of:

- **the Maternity Services Patient Safety Survey**
- **template letters for NHS boards to adapt for local use**
  - **pre-engagement letter**
  - **letter to enclose with survey link**
  - **reminder letter**
  - **thank you letter**
- **an example improvement plan template.**

A template poster and feedback presentation are provided separately for NHS boards to adapt for local use.

All resources are available to download from the Maternity Care Community on the Knowledge Network: [www.knowledge.scot.nhs.uk/maternitycare.aspx](http://www.knowledge.scot.nhs.uk/maternitycare.aspx)  
An Athens log-in is required to access this site.

## Role of maternity care team at Healthcare Improvement Scotland

The maternity care team of the Maternity and Children Quality Improvement Collaborative (MCQIC) of the Scottish Patient Safety Programme (SPSP) are on hand to provide advice on the roll-out of the climate survey, including priming and engaging staff, and how to develop improvement plans based on your results. The maternity care team will not receive individual responses and will not be involved in the analysis of any data. NHS boards are free to share the results with the maternity care team if input into specific areas for improvement is required.

NHS boards will be expected to report to the maternity care team of MCQIC SPSP through the regular measurement reporting mechanism (currently the Excel workbook known as the Maternity Care Toolkit) on the:

- completion of the Maternity Services Patient Safety Survey, and
- development and implementation of an improvement plan in order to drive improvements in safety culture.

## Why safety culture in maternity services?

“““

**To err is human, to cover up is unforgivable and to fail to learn is inexcusable.<sup>2</sup>**

– Sir Liam Donaldson

### What is safety culture?

Patient safety is a critical component of healthcare quality. As healthcare organisations continually strive to improve, there is a growing recognition of the importance of establishing a culture of safety. Key recommendations of the Mid Staffordshire NHS Foundation Trust public enquiry cite the importance of establishing a shared, common safety culture that is patient focused.<sup>3</sup> Achieving a culture of safety requires an understanding of the values, beliefs and norms about what is important in an organisation, and what attitudes and behaviours related to patient safety are expected and appropriate.

## Safety culture

The safety culture of an organisation is the product of individual and group values, attitudes, perceptions, competencies and patterns of behaviour that determine the commitment to, and the style and proficiency of, an organisation's health and safety management. Organisations with a positive safety culture are characterised by communications founded on mutual trust, by shared perceptions of the importance of safety, and by confidence in the efficacy of preventative measures.

Health and Safety Commission (of Great Britain) (1993) *Organising for Safety: Third Report of the Advisory Committee on the Safety of Nuclear Installations (ACSNI) Study Group on Human Factors*. Sudbury, England, HSE books.

A strong safety culture is one which is informed, flexible, promotes learning, encourages reporting and is just.<sup>4</sup> A positive and strong safety culture is essential to improve and assure patient safety. Building a safety culture is therefore strongly promoted as an important activity for all NHS organisations.<sup>5</sup>

Healthcare teams with a positive safety culture are more likely to learn openly and effectively from error and harm.<sup>6</sup> The prevailing safety culture also influences the priorities of every healthcare worker and helps to shape their discretionary safety-critical attitudes and behaviours.<sup>7</sup>

Assessing safety culture at ward/unit level and organisational level provides a 'snapshot' of the prevailing culture at a given moment in time and is one step towards change. This snapshot in time is called safety climate. Safety culture and safety climate are often used interchangeably (see Appendix A for definitions).

## Measuring safety climate

Safety climate is normally measured quantitatively through the use of a validated survey. A safety climate survey\* is a useful tool for identifying gaps and areas of culture in need of improvement. Additional benefits include increasing awareness of patient safety and a basis for internal and external benchmarking. The biggest challenge in assessing culture is to establish a link between safety climate and culture and patient outcomes. Therefore planned evaluation is essential for determining the effectiveness of interventions over time.

Being able to 'measure' climate is an essential component of improving culture; however effecting change requires more than just measurement. Sustained and meaningful change requires a broader 'safety culture approach' incorporating elements of strong leadership, communication, collaboration and learning<sup>+</sup>.

This process would be iterative and approaches will evolve over time.

Measuring safety climate has various potential benefits which can be described at different levels or settings:

- **Individual team member** – safety climate surveys may increase awareness of safety and safety related conditions and behaviours. It also allows an opportunity for them to share their perceptions with the team in general and management in particular.
- **Ward/Unit level** – safety climate surveys may have application as a diagnostic and educational tool by:
  - allowing the team to measure their safety climate
  - prioritising, designing and implementing initiatives to build a stronger safety culture, and
  - evaluating the team's progress through periodic surveys.
- **Hospital level** – safety climate survey perceptions of the various wards/units and teams providing maternity services may be monitored, compared and potentially influenced positively over time.
- **Board level** – safety climate perceptions of the entire maternity service, which may be delivered across multiple hospitals and teams may be monitored, compared and potentially influenced positively over time.

\*The safety climate survey to be used in maternity services is discussed in more detail in Section 3.

<sup>+</sup>Please refer to the Maternity Care Leadership and Culture Driver Diagram and Change Package.

## Differences in perceptions

A consistent and main finding of the vast majority of safety climate surveys – irrespective of industry or setting – is that respondents who are considered ‘management’ because of seniority and/or management roles, generally perceive the organisation’s safety climate to be significantly more positive than those in the ‘non-management’ group. This finding has serious implications for patient safety, as the number of safety-related incidents increases with the degree of variation in perception between different staff groups.<sup>8</sup> In practice, determining which group’s perceptions are closer to reality can be very difficult and even unhelpful. So, while it might be tempting to speculate or attempt to determine which staff group’s perception is closer to reality, it is the degree of variation between the groups that should be considered.

## Why maternity services?

Maternity services have robust professional and organisational standards. However when things go wrong, this can have a devastating effect on service users and staff. Understanding the root cause of these cases and working together to improve communication and consistency of standards is key to the Maternity Care strand of MCQIC and moving maternity services forward. To achieve this, a safe and just culture is required for organisational learning.

Frontline maternity staff involved in the pilot highlighted that participation in the survey gave them an opportunity to provide honest feedback about safety culture in their work area. Feedback sessions were also noted by staff as an opportunity to discuss the findings. By participating, staff also felt a greater sense of involvement and appreciation.

Again learning from the pilot process, frontline staff felt that they had the potential to directly contribute to the improvement of local safety culture. At one pilot site, communication at handover was identified as an area for improvement. As a result, frontline staff and senior managers worked together to develop a handover tool and have made handovers ‘protected time’ for staff. This is ongoing collaborative work that is being progressed as a result of undertaking the safety culture survey.

# How?

## The survey tool

The measurable components of safety culture are often referred to as safety climate. A safety climate survey aims to provide each member of the relevant workforce the opportunity to complete an anonymous questionnaire about different elements of safety climate.

The survey that will be used as part of SPSP for Maternity Care is an adapted version of the Hospital Survey on Patient Safety and Culture (HSOPSC). The HSOPSC, developed by the Agency for Healthcare Research and Quality (AHRQ) in the United States, has been formally validated for use in acute hospital settings in Scotland.<sup>9</sup> Community maternity teams constitute an important component of Scotland's maternity services; as such the language within the survey has been adapted and tested to ensure it is suitable for use in both inpatient and community settings. A copy of the survey can be found in Appendix C. This adapted survey is referred to as the Maternity Services Patient Safety Survey.

## Safety culture dimensions measured in the survey

The survey places an emphasis on patient safety issues and on error and event reporting.

The survey measures seven unit-level aspects of safety culture:

- supervisor/manager expectations and actions promoting safety (4 items)
- organisational learning - continuous improvement (3 items)
- teamwork within wards/units (4 items)
- communication openness (3 items)
- feedback and communication about error (3 items)
- nonpunitive response to error (3 items)
- staffing (4 items).

The survey also measures three hospital-level aspects of safety culture:

- management support for patient safety (3 items)
- teamwork across wards/units (4 items)
- handovers and transitions (4 items).

Finally, four outcome variables are included:

- overall perceptions of safety (4 items)
- frequency of event reporting (3 items)
- patient safety grade (of the hospital) (1 item)
- number of events reported (1 item).

## Preparation

### Identification of project team

To support and implement safety culture work, a project team needs to be identified. Ideally, the team should comprise representatives from key professional groups, but it should not be too cumbersome.

A suggested team membership is provided below:

- SPSP maternity champion
- safety culture champion
- SPSP programme manager – to provide leadership in relation to quality improvement
- obstetrician
- anaesthetist
- administrative staff
- data manager
- manager.

In planning the membership of the project team, maternity services should consider sustainability and factor this in from the start of the project.

The project team is responsible for a variety of duties, these include:

- **planning** – allocating time scales for the project, from pre work, rollout, analysis, feeding back of results and developing improvement plans
- **defining the sample** – determining which staff to survey
- **establishing ward level contact persons** – identifying ward contacts to support survey administration
- **preparing survey materials** – printing surveys (if applicable)
- **issuing survey materials** – distributing communication materials, issuing pre-notification letters, surveys and reminders
- **tracking survey responses and response rates**
- **handling data entry (if applicable), analysis, and report preparation**, and
- **feeding back to staff.**

#### **A main point-of-contact – safety culture champion**

There should be one point-of-contact appointed from the project team so that staff will have one central source for their questions or concerns about the survey. Contact details should be included in any promotional materials and within the pre-notification letter. The main point-of-contact has several duties, including:

- answering questions about survey items, instructions, or processes
- responding to staff comments and concerns, and
- communicating with other points-of-contact as necessary.

### **Executive support**

Learning from the pilot site suggests that executive support for the safety culture work is helpful to engage staff in the survey as well as supporting the implementation of improvement plans. Executive support will also be required to ensure dedicated time and resource for the team to oversee the rollout of the survey, feedback processes and development of an improvement plan.

### **Identification of staff**

All staff who directly contribute to providing services within the maternity service should be included. It is useful to think about the following:

- all staff who have direct contact or interaction with women and families (clinical staff, as well as nonclinical staff, such as receptionists and clerks)
- staff who may not have direct contact or interaction with patients, but whose work directly affects patient care (staff in units such as pharmacy, laboratory/pathology)
- clinicians who spend most of their work hours in the maternity service – for example consultant anaesthetists
- supervisors, managers and administrators, and
- staff who come in to contact with patients in the community such as health visitors and midwives.

It is important to decide who should be included so that you can have an idea of numbers and completion rates.

### **Compile your sample list**

After you determine who you want to survey, you need to calculate your staff numbers; this will be your sample size. This will help you keep track of how many responses you are expecting. Make sure you have up-to-date email contact lists for these staff (where possible).

## Staff engagement

### Response rate

The response rate is the total number of complete returned surveys divided by the total number of eligible staff sampled. Achieving a high response rate is very important for making valid generalisations about your maternity service, based on your survey data collection effort. Surveys are used to infer something about a particular population. There must be enough survey respondents to accurately represent the maternity service before you can legitimately present your survey results as a reflection of your maternity service's safety culture.

If your response rate is low, there is a danger that the large number of staff who did not respond to the survey would have answered very differently from those who did respond. Therefore, an overall response rate of 60% or more should be your minimum goal. The higher the response rate, the more confident you can be that you have an adequate representation of the staff's views.

Learning from maternity units who have undertaken previous work on culture, and the SPSP Primary Care Team, thorough and intensive preparatory work is key to survey completion rates and therefore the overall success of the survey.

### Ideas for improving response rates

Although each NHS board will know what works best for them locally, here are some suggestions:

- **Run seminars or briefing sessions** for staff to tell them about:
  - the culture work (why it's important, how staff can contribute)
  - the process for analysing and feeding back the results
  - plans for developing improvement plans from the results, and
  - timescales.

Pilot sites found that informal drop-in sessions, where staff could pop in to find out more and ask questions, worked better than more formal, structured sessions.

- **Develop posters** to display in staff areas to make them aware that the survey is coming (supplied in addition to this Handbook).
- **Peer champions** – identifying key staff in peer groups to generate buy-in from that particular staff group, for example consultant obstetricians generating engagement from their obstetric colleagues, and midwives encouraging midwives to complete the survey was found to be successful by the pilot sites.
- **Use existing communication mechanisms** – use pre-existing mechanisms, such as all staff safety briefings or huddles.

- **Written communications:**

- **Pre-notification email/letter** – before administering the survey, create a letter signed by an Executive Lead within your NHS board on NHS board letterhead. The letter will inform all the staff in your sample that they will be receiving a survey and that senior management is in full support of the survey effort. A template is provided in Appendix D.
- **Survey** – 1 week after the initial pre-notification letter, send the survey to all staff in your sample. Include a supporting cover letter similar in content to the pre-notification letter and instructions for completing and returning the survey. In the cover letter, or on the survey form, ask staff to complete the survey within 7 days, but do not print an actual deadline date on the letter or survey. Sometimes data collection schedules get delayed, and you do not want to reprint letters or surveys because they are outdated. In addition, sometimes people will not complete a survey if they notice that it is beyond the deadline date. A template is provided in Appendix E.
- **First reminder email/letter** – approximately 2 weeks after sending the survey, send a reminder to the sample group thanking those who have already responded and reminding others to please respond. A template is provided in Appendix F.
- **Second reminder email/letter (optional)** – approximately 1 week after sending the follow-up letter, you may choose to send a second and final reminder.
- **Thank you email/letter** – once the survey is closed, send a thank you letter to all staff advising of when feedback sessions will be. A template is provided in Appendix G. This was appreciated by staff in the pilot sites.

All the above resources are available to download from the Maternity Care Community on the Knowledge Network ([www.knowledge.scot.nhs.uk/maternitycare.aspx](http://www.knowledge.scot.nhs.uk/maternitycare.aspx)). An Athens log-in is required to access this site.

- **Reassure anonymity** – learning from the pilot sites, a potential barrier to staff participating is the perceived risk of being identified. Assurance that individual responses are not identifiable is essential. In the pilot process, the use of email and electronic forms were identified as potential areas of concern regarding anonymity. Staff need to be reassured that by completing the survey, either electronically or on paper, at no point can responses be linked back to individuals.

Throughout the duration of the survey you may wish to:

- display information on the NHS board's intranet site, and
- announce the survey in hospital newsletters.

## Roll-out of the survey

The project team will need to consider how staff are best able to complete the survey. Learning from the pilot sites suggests that a mixed methods approach using an electronic tool and paper copies allows significantly more staff to complete the survey than using solely one approach. It is recommended that the survey is kept open for a minimum of 4 weeks to allow staff on rolling shift patterns to complete the survey. Lessons learned from pilot sites about the use of paper electronic systems are outlined below.

### Paper copies of questionnaire

- Make sure that you have enough printed copies of the questionnaire before you start the pre-engagement work.
- If using home postal addresses - make sure you have up-to-date addresses for staff, finance / payroll systems are often the most up-to-date source of information (note: junior doctors are not always on the department payroll therefore a different approach will be required).
- If using internal mail systems, make sure that these are robust and are checked by staff frequently.
- Identify staff to hand paper copies of the survey to staff groups if appropriate.

### Electronic systems

- Make sure you have up to date email addresses for staff (note: some medical staff chose to use their academic email addresses).
- All of the electronic systems noted in Appendix H protect staff confidentiality. Staff are not able to be monitored or identified by clicking on the hyperlink to the electronic survey. It is important that this is reinforced to staff throughout the process.

There are a number of electronic tools which can be used, and the pros and cons of these are outlined in Appendix H.

## Collating surveys

Paper surveys will need to be entered into a repository in order to analyse the results. As a mixed methods approach is recommended, it is advocated that the results are entered into an electronic system (see comparison of electronic system in Appendix H).

## Calculating your response rate

To calculate your survey response rate, divide the number of completed and returned surveys (numerator) by the number of surveys sent (denominator).

Each survey needs to be examined for completeness, before entering the survey responses into the data set. At a minimum, the AHRQ retain only those surveys in which the respondents complete at least one whole section of the survey. If a respondent has not answered most of the items in at least one section of the survey, you will be missing relevant data on too many items. This will become problematic when calculating the safety culture composite scores. Therefore, the following criteria are recommended to identify incomplete surveys and exclude them from your data set. Exclude the responses from a survey form if the respondent answered:

- less than one entire section of the survey.
- fewer than half of the items throughout the entire survey (in different sections).
- every item the same (for example all "4"s or all "5"s). If every answer is the same, the respondent did not give the survey their full attention. The survey includes reverse-worded items that exercise both the high/positive and low/negative ends of the response scale to provide consistent answers.

## Analysis of the questionnaires

### Numerical response questions

The survey items can be grouped into dimensions of safety culture, and so it can be useful to calculate one overall frequency for each dimension. One way of doing this is to create a composite frequency of the total percentage of positive responses for each safety culture dimension. Composites can be computed for individual wards/units or sections of a hospital, or for the hospital as a whole. For example, a composite frequency of 50% on 'Overall Perceptions of Safety' would indicate that 50% of the responses reflected positive opinions about the overall safety in the ward/unit or hospital.

To create an overall composite frequency on a safety culture dimension:

**Step 1** Determine which items are related to the dimension in which you are interested, and which items related to that are reverse worded (negatively worded). Items are grouped by dimension in Appendix I, which also identifies the items that are reverse-worded. There are three or four items in each dimension.

**Step 2** Count the number of positive responses to each item in the dimension —“Strongly Agree/ Agree” or “Most of the time/Always” are positive responses for positively worded items. For reverse worded items, disagreement indicates a positive response, so count the number of “Strongly Disagree/Disagree” or “Never/Rarely” responses.

**Step 3** Count the total number of responses for the items in the dimension (this excludes missing data).

**Step 4** Divide the number of positive responses to the items (answer from step 2) by the total number of responses (answer from step 3).

$$\frac{\text{Number of positive responses to the items in the dimension}}{\text{Total number of responses to the items (positive, neutral, and negative) in the dimension}} \times 100$$

The resulting number is the percentage of positive responses for that particular dimension.

### Open-ended comments boxes/Free text

Respondents are given the opportunity to provide written comments at the end of the survey. Comments can be used to obtain direct quotes for feedback purposes. If you wish to analyse these data further, the responses will need to be coded according to the type of comment that was made. For example, staff may respond with positive comments about patient safety efforts in their ward/unit. Or, they may comment on some negative aspects of patient safety that they think need to be addressed. You may assign code numbers to similar types of comments and later tally the frequency of each comment type. Open-ended comments may be coded either before or after the data have been entered electronically.

## Interpreting the results

An adapted version of the AHRQ Survey Microsoft PowerPoint® presentation has been prepared with modifiable feedback report templates that helps to interpret the results as well as communicating results from the survey to staff.

The feedback report template groups survey items according to the safety culture dimension each item is intended to measure. You can easily adapt the PowerPoint template by inserting your results in the charts to create a customised feedback report. To make the results easier to view in the report, the two lowest response categories have been combined (Strongly Disagree/Disagree and Never/Rarely) and the two highest response categories have been combined (Strongly Agree/Agree and Most of the time/Always). The midpoints of the scales are reported as a separate category (Neither or Sometimes). The percentage of answers corresponding with each of three response categories are then displayed graphically – see the sample graph below displaying frequencies of response to an item.



### Missing responses

Because each survey item most likely will have some missing data, missing responses are excluded from the total (or denominator) when calculating these percentages. In the example shown, assume there were 200 total survey respondents. Twenty people did not answer this particular item, so the total number of people who responded to the item was 180. The percentage of respondents who Strongly Agreed/Agreed was 50% or 90/180. The percentage of respondents who either Strongly Disagreed/Disagreed or responded “Neither” was 25% or 45/180. Excluding missing data from the total allows the percentages of responses within a graph to sum to 100 (actually 99 to 101, due to the rounding of decimals to whole numbers).

### Strengths

There are placeholder pages in the electronic feedback report template for highlighting strengths and areas needing improvement, respective of patient safety issues covered in the survey. Patient safety strengths are defined as those positively worded items that about 75% of respondents endorsed by answering “Strongly Agree/Agree” or “Always/Most of the time” (or those negatively worded items that about 75% of respondents disagreed with). The 75% cut-off is somewhat arbitrary, and your maternity service may choose to report strengths using a higher or lower cut-off percentage.

### Areas for improvement

Similarly, areas needing improvement are identified as those items that 50% or fewer respondents did not answer positively (they either answered negatively or “Neither” to positively worded items, or they agreed with negatively worded items). The cut-off percentage for areas needing improvement is lower, because if half of the respondents are not expressing positive opinions about a safety issue, there probably is room for improvement.

### Adapting the feedback report template

The feedback report template can be adapted for local use. It may be appropriate to use all the slides in some settings; however you may wish to remove some slides in smaller group settings to highlight key/specific areas.

The feedback report template contains a number of slides that require local information to be entered and should be populated once the survey has been completed.

The first slide of the feedback report template includes space to enter local details such as hospital name, ward and the contact details of the local safety culture champion who staff can contact for more information.

The third slide describes the local sample and data collection methodology. Type over the underlined text with the relevant details.

Slides 4 and 5 summarise respondent demographics. Type the relevant percentages against each element.

Slides 6 and 7 highlight key strengths and areas for improvement respectively. Type the relevant strengths and areas for improvement as defined on pages 17 and 18.

Slides 8, 9 and 12–21 contain graphs to help display responses to each of the statements.

To add the results to each graph:

1. Right click on the border of the chart area and select ‘Edit data’.
2. An Excel spreadsheet should appear that supports the series of graphs on the slide.
3. Enter the relevant data (i.e. % response) for each question onto the spreadsheet.
4. The graphs on the slide should automatically update as the data are entered onto the spreadsheet – the width of each cell on the graph will change according to the % entered.
5. Once you have finished entering data for a specific slide, close the Excel spreadsheet and move on to the next slide.
6. Repeat the above steps to complete the remaining slides with these graphs.

Slides 10 and 11 contain bar graphs. To add your results to these graphs follow the process described above by right clicking on the border of the chart area, select ‘Edit data’ and enter the relevant results into the excel spreadsheet.

Slides 22 and 23 provide space to share quotations or themes from the comments section of the survey.

Note: The colours used in the PowerPoint presentation are deliberately neutral, please do not change the colours, for example to red / amber / green (RAG), as use of RAG ratings may be misleading to staff.

## Feedback

### Preparing feedback

Learning from the pilot sites highlighted the benefit of having an objective facilitator (for example an individual who does not work in maternity care services) present with the project team when the feedback is being prepared. It is not uncommon for frontline staff and managers to adopt default positions in their perceptions and analysis of results and objective facilitators can ameliorate this.

### Reports

Ideally, feedback should be provided broadly to maternity services management, NHS board management, maternity services committees, and to hospital staff, either through their wards/units or through a centralised communications tool such as email or newsletters. The more broadly the results are disseminated, the more useful the information is likely to become. The feedback will also serve to legitimise the collective effort of the respondents and their participation in the survey. It is gratifying and important for respondents to know that something worthwhile came out of the information they provided. Different types of feedback reports can be prepared for each different audience, from one or two-page executive summaries to more complete reports that use statistics to draw conclusions or make comparisons.

### Feedback sessions

#### Workshops with staff members

Workshops with staff can be a good way to contextualise the report. It may be useful to hold separate workshops for specific staff groups if there are results that are more relevant to them. A facilitator's guide to aid discussion can be found in Appendix J.

Staff in the pilot sites appreciated face-to-face feedback of the results, allowing further discussion and clarification of any issues identified. Ideally, peers should provide the feedback and discuss results. There is the danger if managers are used to feedback results that this is misinterpreted as a '*You said, we did*' approach which would contradict a '*safety culture is everyone's business*' aim.

## Development of quality improvement plans

Local Improvement Advisors and Fellows can assist with interpreting the results and the development of improvement plans. They may have the benefit of being impartial to the results and will be key in generating ideas for improvement and will be able to share learning from other sites/areas. An example template improvement plan is included in Appendix K.

A suggested timeline to implement the survey as well as developing your quality improvement plan and implementation is provided below.

	Month 1	Month 2	Month 3	Month 4	Month 5
<b>Identify local safety culture champion and project team</b> <ul style="list-style-type: none"> <li>Hold planning meeting</li> </ul>					
<b>Pre-engagement work</b> <ul style="list-style-type: none"> <li>Send email</li> <li>Put up posters</li> <li>Hold staff briefing sessions</li> </ul>					
<b>Survey live</b> <ul style="list-style-type: none"> <li>Survey live for 4 weeks</li> </ul>					
<b>Analysis of results</b> <ul style="list-style-type: none"> <li>Identify strengths and areas for improvement</li> </ul>					
<b>Feedback of results to staff</b> <ul style="list-style-type: none"> <li>Group sessions</li> <li>Peer to peer</li> </ul>				Confirm date	
<b>Develop improvement plan</b>					
<b>Start implementing improvement plan</b>					Confirm date

## When?

It is expected that NHS boards monitor progress with an update on actions to the Board and repeat the survey annually.

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## Appendix A – Glossary

### **Maternity service\***

All inpatient and outpatient care providing maternity care linked to one hospital. This could be then split into inpatient maternity services and outpatient maternity services.

### **Measuring safety climate**

Safety climate has to be measured first before it can be understood or improved. High risk industries such as aviation, the nuclear energy and petro-chemical sectors have been measuring safety climate for many years. In healthcare safety climate measurement is well established in secondary care settings in the US, while there is progress in some acute hospitals in the UK. Safety climate is most commonly measured through questionnaire surveys.

### **Safety climate**

The term 'safety climate' refers to the measurable components of safety culture. Safety climate provides a snap shot of culture at a given moment in time.<sup>10,11,12</sup>

### **Safety culture**

Safety culture is commonly defined as 'the product of individual and group values, attitudes, perceptions and patterns of behaviour that determine a team or organisation commitment to safety management'.<sup>13</sup> It is widely accepted that every organisation and team have a culture which permeates all parts of it. While the influence of a culture cannot be observed directly, its impact becomes apparent in the behaviour of individuals. This is the reason for the well known and practical definition of safety culture as 'the way things are done around here'.<sup>14</sup>

### **Safety climate questionnaire**

Safety climate surveys typically require the workforce to complete the self report questionnaire anonymously on a periodic basis. The individual scores are aggregated to provide a 'snapshot' of the overall safety climate and of those factors to be important aspects of safety climate in the workplace.

The hierarchical and organisational nature of the NHS potentially many allow safety climate to be examined, compared, monitored, and improved at different levels of example work groups (for example the nursing profession or administrative staff) and organisation.

### **Unit/Ward\***

Any inpatient areas that provide maternity care (for example labour suite, antenatal ward, theatres, post-natal ward) and in the outpatient setting any discrete team/area that provides maternity care (for example an outreach team, community clinic, community team).

\*For the purposes of the Safety Culture Handbook the above definitions have been used. It is acknowledged that these terms may be used differently in practice.

## Appendix B – Acknowledgements

Thanks to members of the Safety Culture Short Life Working Group:

<b>Corinne Love</b>	Obstetric Clinical Lead, Maternity Care Strand, Maternity and Children Quality Improvement Collaborative (MCQIC) (Co-Chair)
<b>Bernie McCulloch</b>	Improvement Advisor, MCQIC (Co-Chair)
<b>Elaine Cockburn</b>	Professional Advisor Public Health: Midwifery Care, Maternal & Infant Health, Scottish Government
<b>Hannah Cornish</b>	Senior Project Officer, MCQIC
<b>Angela Cunningham</b>	Midwifery Clinical Lead, Maternity Care Strand, MCIQIC
<b>Shelly Jeffcott</b>	Improvement Advisor, Quality Improvement Hub, Healthcare Improvement Scotland
<b>David Maxwell</b>	Associate Improvement Advisor, Maternity Care Strand, MCQIC
<b>Lorna McKee</b>	Professor of Management Delivery of Care Programme Director, Health Services Unit, University of Aberdeen
<b>Sandra McNaught</b>	Maternity Champion & Midwife, NHS Greater Glasgow and Clyde
<b>Lynne Nicol</b>	Head of Maternal & Infant Health Branch, Scottish Government
<b>Julia Scott</b>	SPSP Programme Manager, NHS Borders
<b>Alexandra Stirling</b>	Acting Consultant in Public Health Medicine, NHS Ayrshire & Arran
<b>Dawn Wilson</b>	Project Officer, Maternity Care Strand, MCQIC

Thanks to members of the Scottish Patient Safety Programme Primary Care Team:

<b>Jill Gillies</b>	Improvement Advisor
<b>Leanne Marshall</b>	Project Officer
<b>Mike Gurajek</b>	Project Administrator

## Appendix C – Maternity Services Patient Safety Survey

### Maternity Services Patient Safety Survey

#### Instructions

This survey asks for your opinions about patient safety issues, medical error, and event reporting in your hospital and will take about 10 to 15 minutes to complete.

**Please return the survey to:**

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

- An “**event**” is defined as any type of error, mistake, incident, accident, or deviation, regardless of whether or not it results in patient harm.
- “**Patient safety**” is defined as the avoidance and prevention of patient injuries or adverse events resulting from the processes of health care delivery
- For the purpose of this survey “**patient**” refers to women and babies.

All resources are available to download from the Maternity Care Community on the Knowledge Network: [www.knowledge.scot.nhs.uk/maternitycare.aspx](http://www.knowledge.scot.nhs.uk/maternitycare.aspx)

**SECTION A: Your Work Area/Unit**

In this survey, think of your “unit” as the work area, ward, or clinical area of the hospital where you spend **most** of your work time or provide **most** of your clinical services.

Where is your primary work area in this maternity service? Select **ONE** answer.

- a. Hospital – Antenatal ward
- b. Hospital – Labour ward
- c. Hospital – Postnatal ward
- d. Hospital – Outpatient clinic
- e. Hospital – Triage
- f. Hospital – Theatres
- g. Hospital - Radiology/  
Ultrasonography
- h. Community setting
- i. Other, please specify:

Please indicate your agreement or disagreement with the following statements about your work area/unit.

Think about your hospital work area/unit...	Strongly Disagree ▼	Disagree ▼	Neither ▼	Agree ▼	Strongly Agree ▼
1. People support one another in this unit .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
2. We have enough staff to handle the workload .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
3. When a lot of work needs to be done quickly, we work together as a team to get the work done .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
4. In this unit, people treat each other with respect .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
5. Staff in this unit work longer hours than is best for patient care .....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

**SECTION A: Your Work Area/Unit (continued)**

<b>Think about your hospital work area/unit...</b>	<b>Strongly Disagree ▼</b>	<b>Disagree ▼</b>	<b>Neither ▼</b>	<b>Agree ▼</b>	<b>Strongly Agree ▼</b>
6. We are actively doing things to improve patient safety .....	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
7. We use more agency/temporary staff than is best for patient care .....	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
8. Staff feel like their mistakes are held against them .....	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
9. Mistakes have led to positive changes here .....	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
10. It is just by chance that more serious mistakes don't happen around here.....	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
11. When one area in this unit gets really busy, others help out .....	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
12. When an event is reported, it feels like the person is being written up, not the problem.....	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
13. After we make changes to improve patient safety, we evaluate their effectiveness.....	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
14. We work in "crisis mode" trying to do too much, too quickly.....	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
15. Patient safety is never sacrificed to get more work done .....	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
16. Staff worry that mistakes they make are kept in their personnel file .....	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
17. We have patient safety problems in this unit .....	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
18. Our procedures and systems are good at preventing errors from happening.....	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>

**SECTION B: Your Manager**

**Please indicate your agreement or disagreement with the following statements about your immediate manager or person to whom you directly report.**

	<b>Strongly Disagree ▼</b>	<b>Disagree ▼</b>	<b>Neither ▼</b>	<b>Agree ▼</b>	<b>Strongly Agree ▼</b>
1. My manager says a good word when he/she sees a job done according to established patient safety procedures .....	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
2. My manager seriously considers staff suggestions for improving patient safety .....	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
3. Whenever pressure builds up, my manager wants us to work faster, even if it means taking shortcuts .....	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
4. My manager overlooks patient safety problems that happen over and over.....	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>

**SECTION C: Communications**

How often do the following things happen in your work area/unit?

Think about your hospital work area/unit...	Never ▼	Rarely ▼	Some- times ▼	Most of the time ▼	Always ▼
1. We are given feedback about changes put into place based on event reports.....	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
2. Staff will freely speak up if they see something that may negatively affect patient care .....	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
3. We are informed about errors that happen in this unit .....	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
4. Staff feel free to question the decisions or actions of those with more authority .....	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
5. In this unit, we discuss ways to prevent errors from happening again .....	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
6. Staff are afraid to ask questions when something does not seem right ....	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>

**SECTION D: Frequency of Events Reported**

In your hospital work area/unit, when the following mistakes happen, how often are they reported?

	Never ▼	Rarely ▼	Some- times ▼	Most of the time ▼	Always ▼
1. When a mistake is made, but is <i>caught and corrected before affecting the patient</i> , how often is this reported?.....	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
2. When a mistake is made, but has <i>no potential to harm the patient</i> , how often is this reported? .....	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
3. When a mistake is made that <i>could harm the patient</i> , but does not, how often is this reported? .....	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>

**SECTION E: Patient Safety Grade**

Please give your work area/unit in this hospital an overall grade on patient safety.

<input type="checkbox"/>				
<b>A</b>	<b>B</b>	<b>C</b>	<b>D</b>	<b>E</b>
Excellent	Very Good	Acceptable	Poor	Failing

**SECTION F: Your Hospital**

Please indicate your agreement or disagreement with the following statements about your hospital.

Think about your hospital...	Strongly Disagree ▼	Disagree ▼	Neither ▼	Agree ▼	Strongly Agree ▼
1. Hospital management provides a work climate that promotes patient safety .....	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
2. Hospital units do not coordinate well with each other.....	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
3. Things “fall between the cracks” when transferring patients from one unit to another.....	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
4. There is good cooperation among hospital units that need to work together .....	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>

**SECTION F: Your Hospital (continued)**

Think about your hospital...	Strongly Disagree ▼	Disagree ▼	Neither ▼	Agree ▼	Strongly Agree ▼
5. Important patient care information is often lost during shift changes .....	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
6. It is often unpleasant to work with staff from other hospital units .....	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
7. Problems often occur in the exchange of information across hospital units .....	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
8. The actions of hospital management show that patient safety is a top priority .....	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
9. Hospital management seems interested in patient safety only after an adverse event happens .....	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
10. Hospital units work well together to provide the best care for patients.....	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
11. Shift changes are problematic for patients in this hospital.....	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>

**SECTION G: Number of Events Reported**

**In the past 12 months, how many event reports have you filled out and submitted?**

- |  |  |
|--|--|
| <input type="checkbox"/> a. No event reports     | <input type="checkbox"/> d. 6 to 10 event reports    |
| <input type="checkbox"/> b. 1 to 2 event reports | <input type="checkbox"/> e. 11 to 20 event reports   |
| <input type="checkbox"/> c. 3 to 5 event reports | <input type="checkbox"/> f. 21 event reports or more |

**SECTION H: Background Information**

**This information will help in the analysis of the survey results.**

**1. How long have you worked in this hospital?**

- |  |  |
|--|--|
| <input type="checkbox"/> a. Less than 1 year | <input type="checkbox"/> d. 11 to 15 years   |
| <input type="checkbox"/> b. 1 to 5 years     | <input type="checkbox"/> e. 16 to 20 years   |
| <input type="checkbox"/> c. 6 to 10 years    | <input type="checkbox"/> f. 21 years or more |

**2. How long have you worked in your current hospital work area/unit?**

- |  |  |
|--|--|
| <input type="checkbox"/> a. Less than 1 year | <input type="checkbox"/> d. 11 to 15 years   |
| <input type="checkbox"/> b. 1 to 5 years     | <input type="checkbox"/> e. 16 to 20 years   |
| <input type="checkbox"/> c. 6 to 10 years    | <input type="checkbox"/> f. 21 years or more |

**3. Typically, how many hours per week do you work in this hospital?**

- |   |  |
|---|--|
| <input type="checkbox"/> a. Less than 20 hours per week | <input type="checkbox"/> d. 60 to 79 hours per week    |
| <input type="checkbox"/> b. 20 to 39 hours per week     | <input type="checkbox"/> e. 80 to 99 hours per week    |
| <input type="checkbox"/> c. 40 to 59 hours per week     | <input type="checkbox"/> f. 100 hours per week or more |

**SECTION H: Background Information (continued)**

**4. Which of the following best describes the terms of your employment?**

- a. Permanent (including full time, part time and seconded posts)
- b. Bank
- c. Agency

**5. What is your staff position in this hospital? Select ONE answer that best describes your staff position.**

Midwifery

- a. Consultant Midwife
- b. Supervisor of Midwives
- c. Midwife
- d. Student Midwife

Paediatrics

- o. Consultant
- p. Associate Specialist
- q. FY1 / FY2 / ST / staff grade

Nursing

- e. Registered Nurse
- f. Advanced Neonatal Nurse Practitioner
- g. Nursing Assistant
- h. Student nurse

Neonatology

- r. Consultant
- s. Associate Specialist
- t. FY1 / FY2 / ST / staff grade

Obstetrics

- i. Consultant
- j. Associate Specialist
- k. FY1 / FY2 / ST / staff grade

- u. Maternity Care Assistant / Clinical Support Worker
- v. Operating department practitioner
- w. Pharmacist
- x. Allied Health Professional
- y. Support staff / Portering / Domestic / Catering

Anaesthetics

- l. Consultant
- m. Associate Specialist
- n. FY1 / FY2 / ST / staff grade

- z. Sonographer / Radiographer
- aa. Medical records / clerkess / secretary
- ab. Manager

<input type="checkbox"/> ac. Other, please specify:

**6. In your staff position, do you typically have direct interaction or contact with patients?**

- a. YES, I typically have direct interaction or contact with patients.
- b. NO, I typically do NOT have direct interaction or contact with patients.

**7. How long have you worked in your current specialty or profession?**

- a. Less than 1 year
- b. 1 to 5 years
- c. 6 to 10 years
- d. 11 to 15 years
- e. 16 to 20 years
- f. 21 years or more

**SECTION I: Your Comments**

**Please feel free to write any comments about patient safety, error, or event reporting in your hospital.**

***THANK YOU FOR COMPLETING THIS SURVEY.***

## Appendix D – Template engagement letter

### Send 1 week before survey go live date



NHS Board details  
Xxx  
Xxx  
xxx

Dear xxx

#### Patient safety – how are we doing?

Now's your chance to tell us! The maternity services patient safety survey will be arriving in your inboxes shortly.

Achieving a culture of safety requires an understanding of the values, beliefs, and norms about what is important in an organisation and what attitudes and behaviours related to patient safety are expected and appropriate. NHS xxx is therefore launching a maternity services patient safety survey as part of our continued efforts to better address patient safety and we want to hear how we're doing.

Within the next week you will receive a link to an online survey. Paper copies will also be available from xxx. The survey is being distributed to all members of staff who work within the xxx maternity unit. This includes midwives, medical staff as well as managers and support staff.

Over the 4 weeks the results will be collated and analysed by xxx. Your response is confidential and anonymous. Staff briefing sessions will be held on [time, venue, location] to provide feedback to staff on the survey results and discuss the way forward. An improvement plan will be developed and acted upon as a result of the information gathered from this survey.

Please contact [name, position, phone number and email address] if you have any questions about the survey or how the results will be used.

We look forward to working with you on our patient safety journey. Thank you in advance for your participation in this important effort.

Best wishes

Xxxx

## Appendix E – Covering letter to be sent with the survey



NHS Board details  
Xxx  
Xxx  
xxx

Dear xxx

### Safety Culture in Maternity Services

The maternity services patient safety survey has arrived! The survey is now live and can be accessed through the following link xxx. Alternatively paper copies can be found xxx.

The survey will take between 10 and 15 minutes to complete. Your individual responses will be kept confidential and anonymous. Only group statistics will be prepared from the survey results.

Please complete the survey online or return a hard copy to xxx within the next 28 days.

Senior management within the maternity unit and at Board level are committed to working with you to improve patient safety. We look forward to hearing from you.

Staff briefing sessions will be held on [time, venue, location] to provide feedback to staff on the survey results and discuss the way forward. An improvement plan will be developed and acted upon as a result of the information gathered from this survey.

Please contact [name, position, phone number and email address] if you have any questions about the survey or how the results will be used.

We look forward to working with you on our patient safety journey. Thank you in advance for your participation in this important effort.

Best wishes

Xxxx

## Appendix F – Reminder letter

### To be sent 2 weeks into the survey (assumes survey will be open for 4 weeks)



NHS Board details

Xxx

Xxx

xxx

Dear xxx

How safe is your maternity unit? We're sure you have an opinion, and we'd love to hear it!

Thank you to all of you who have taken the time to complete the maternity services patient safety survey. If you haven't, there is still time to help improve patient safety. Please take just 10 minutes to tell us what you think. The survey is now live and can be accessed through the following link xxx. Alternatively paper copies can be found xxx.

Your individual responses will be kept confidential and anonymous. Only group statistics will be prepared from the survey results.

Please complete the survey online or return a hard copy to xxx within the next 14 days.

Staff briefing sessions will be held on [time, venue, location] to provide feedback to staff on the survey results and discuss the way forward. An improvement plan will be developed and acted upon as a result of the information gathered from this survey.

Please contact [name, position, phone number and email address] if you have any questions about the survey or how the results will be used.

Thank you in advance for your participation in this important effort.

Best wishes

Xxxx

## Appendix G – Thank you letter



NHS Board details

Xxx

Xxx

xxx

Dear xxx

Thank you for taking the time to complete the maternity services patient safety survey. The results are currently being collated and analysed and a report will be distributed to all staff shortly.

If you'd like to find out what we're doing with all the information you took the time to give us, please come along to a staff debrief session at any of the following times:

- [Date] at [time] in [venue]
- [Date] at [time] in [venue]
- [Date] at [time] in [venue]

Thank you again for your participation in this important effort.

Best wishes

Xxxx

## Appendix H – Comparison of electronic systems

<b>Survey Monkey -</b> Responses are entered into an electronic survey tool run by external private provider	
<b>Readiness</b>	<ul style="list-style-type: none"> <li>• Ready to go</li> <li>• System currently in existence</li> <li>• NHS boards would need to set up questionnaire within the system for local use</li> </ul>
<b>Input method</b>	<ul style="list-style-type: none"> <li>• Electronic</li> <li>• Data input resource required if units decide to use paper copies</li> <li>• Can be used by a number of users simultaneously</li> </ul>
<b>Information analysis</b>	<ul style="list-style-type: none"> <li>• Responses can be downloaded to a number of different formats including excel, PDF and formatted for SPSS</li> <li>• PDF summary document currently generated provides the information to populate HSOPSC feedback template</li> </ul>
<b>Sustainability/ Ongoing maintenance</b>	<ul style="list-style-type: none"> <li>• Private company</li> <li>• Most NHS boards have Survey Monkey licences</li> </ul>
<b>Information governance</b>	<ul style="list-style-type: none"> <li>• Survey and responses are stored online</li> <li>• Healthcare Improvement Scotland Information Governance Group do not recommend survey monkey for collecting sensitive information – but if boards were to use it locally, this would be for them to decide</li> </ul>
<b>Staff training requirements</b>	<ul style="list-style-type: none"> <li>• Staff are familiar with Survey Monkey as it is used for other things</li> <li>• A number of staff within NHS boards are trained</li> </ul>
<b>Cost</b>	<ul style="list-style-type: none"> <li>• Most NHS boards have a licence as it is used by NHS boards to collect information on a number of topics</li> <li>• There would be no cost to individual units</li> </ul>

**“Do it yourself” -**

NHS boards are provided with a copy of the survey and they make their own arrangements for survey completion and analysis

<b>Readiness</b>	<ul style="list-style-type: none"> <li>• Ready to go</li> </ul>
<b>Input method</b>	<ul style="list-style-type: none"> <li>• System (for example Excel or Access spreadsheet) required to be developed by NHS boards to input results</li> <li>• System would need to be designed so that staff could enter responses to questionnaire themselves</li> </ul>
<b>Information analysis</b>	<ul style="list-style-type: none"> <li>• Analysis would be done manually using tool developed</li> </ul>
<b>Sustainability/ Ongoing maintenance</b>	<ul style="list-style-type: none"> <li>• NHS boards would be responsible for ensuring sustainability of system</li> </ul>
<b>Information governance</b>	<ul style="list-style-type: none"> <li>• Responses stored on local IT system</li> </ul>
<b>Staff training requirements</b>	<ul style="list-style-type: none"> <li>• Staff within NHS boards with appropriate data management and analysis skills would need to identified</li> </ul>
<b>Cost</b>	<ul style="list-style-type: none"> <li>• None – in relation to national system</li> <li>• Significant staff time within NHS board to design information capture tool</li> </ul>

<b>Scannable -</b> Hard copy questionnaires are input by scanning in hard copy questionnaires (for example Formic)	
<b>Readiness</b>	<ul style="list-style-type: none"> <li>• Training required to use the system</li> </ul>
<b>Input method</b>	<ul style="list-style-type: none"> <li>• Useful for when needing to input a large number of hard copy questionnaires and/or long questionnaires</li> <li>• Software can be installed on a number of PCs within an organisation but can only be used by one concurrent user</li> </ul>
<b>Information analysis</b>	<ul style="list-style-type: none"> <li>• Data is saved into a database and can be exported to other formats (for example SPSS)</li> <li>• Can be issues when surveys are not completed "correctly" (for example people do not tick within the box, "scrub" out mistakes or machine cannot read the handwriting) so need to account for some data entry time</li> </ul>
<b>Information governance</b>	<ul style="list-style-type: none"> <li>• Scanned data would be stored on local IT system</li> </ul>
<b>Staff training requirements</b>	<ul style="list-style-type: none"> <li>• More complex system to use, not sure of availability and capacity in NHS boards</li> </ul>
<b>Cost</b>	<ul style="list-style-type: none"> <li>• Additional licences may be expensive</li> </ul>

## Appendix I – Dimensions of the survey

### 1. Outcome Measures

#### Frequency of Event Reporting

- D1. When a mistake is made, but is caught and corrected before affecting the patient, how often is this reported?
- D2. When a mistake is made, but has no potential to harm the patient, how often is this reported?
- D3. When a mistake is made that could harm the patient, but does not, how often is this reported?

#### Overall Perceptions of Safety

- A15. Patient safety is never sacrificed to get more work done.
- A18. Our procedures and systems are good at preventing errors from happening.
- A10r. It is just by chance that more serious mistakes don't happen around here (reverse worded).
- A17r. We have patient safety problems in this unit (reverse worded).

#### Patient Safety Grade

- E1. Please give your work area/unit in this hospital an overall grade on patient safety.

#### Number of Events Reported

- G1. In the past 12 months, how many event reports have you filled out and submitted?

### 2. Safety Culture Dimensions (Unit level)

#### Manager expectations & actions promoting safety

- B1. My manager says a good word when he/she sees a job done according to established patient safety procedures.
- B2. My manager seriously considers staff suggestions for improving patient safety.
- B3r. Whenever pressure builds up, my manager wants us to work faster, even if it means taking shortcuts (reverse worded).
- B4r. My manager overlooks patient safety problems that happen over and over (reverse worded).

#### Organisational Learning - Continuous improvement

- A6. We are actively doing things to improve patient safety.
- A9. Mistakes have led to positive changes here.
- A13. After we make changes to improve patient safety, we evaluate their effectiveness.

#### Teamwork Within Hospital Units

- A1. People support one another in this unit.
- A3. When a lot of work needs to be done quickly, we work together as a team to get the work done.
- A4. In this unit, people treat each other with respect.
- A11. When one area in this unit gets really busy, others help out.

### Communication Openness

- C2. Staff will freely speak up if they see something that may negatively affect patient care.
- C4. Staff feel free to question the decisions or actions of those with more authority.
- C6r. Staff are afraid to ask questions when something does not seem right (reverse worded).

### Feedback and Communication About Error

- C1. We are given feedback about changes put into place based on event reports.
- C3. We are informed about errors that happen in this unit.
- C5. In this unit, we discuss ways to prevent errors from happening again.

### Nonpunitive Response To Error

- A8r. Staff feel like their mistakes are held against them (reverse worded).
- A12r. When an event is reported, it feels like the person is being written up, not the problem (reverse worded).
- A16r. Staff worry that mistakes they make are kept in their personnel file (reverse worded).

### Staffing

- A2. We have enough staff to handle the workload.
- A5r. Staff in this unit work longer hours than is best for patient care (reverse worded).
- A7r. We use more agency/temporary staff than is best for patient care (reverse worded).
- A14r. We work in “crisis mode”, trying to do too much, too quickly (reverse worded).

### Hospital Management Support for Patient Safety

- F1. Hospital management provides a work climate that promotes patient safety.
- F8. The actions of hospital management show that patient safety is a top priority.
- F9r. Hospital management seems interested in patient safety only after an adverse event happens (reverse worded).

## 3. Safety Culture Dimensions (Hospital-wide)

### Teamwork Across Hospital Units

- F4. There is good cooperation among hospital units that need to work together.
- F10. Hospital units work well together to provide the best care for patients.
- F2r. Hospital units do not coordinate well with each other (reverse worded).
- F6r. It is often unpleasant to work with staff from other hospital units (reverse worded).

### Hospital Handoffs and Transitions

- F3r. Things “fall between the cracks” when transferring patients from one unit to another (reverse worded).
- F5r. Important patient care information is often lost during shift changes (reverse worded).
- F7r. Problems often occur in the exchange of information across hospital units (reverse worded).
- F11r. Shift changes are problematic for patients in this hospital (reverse worded).

## Appendix J – Facilitator guide

Here are some reflective questions and potential implications to guide you through discussions at feedback sessions.

### Survey participants

- How many team members participated and how many were expected to have completed? A 60% response rate or above is required for the results to reflect the perceptions of the maternity unit as a whole.
- Do the non participants have specific characteristics in common? If they do, it makes it more difficult to interpret the rest of the report with confidence.
- Why did some team members not participate?

Consider Section 2.1.2 Differences in perceptions and reflect on the responses from managers vs non managers / clinical vs non clinical and look for any obvious differences between staff groups. This should be approached with caution in the smaller units, as this may result in identifying individual responses.

- Are there any obvious differences between staff groups?
- More specifically, is one staff group constantly perceiving things more positively or negatively than another?
- Is the difference only in one area?
- If there are differences between only one group, it is likely to be important.
- Why is there variation between groups? This is a good opportunity to share individual experiences .
- How can perceptions be aligned (if this is considered important)? It can be difficult and counter-productive to try and establish which group is 'right'.

Compare your current safety climate results with your previous perceptions (if applicable).  
Are there any noticeable differences (either more positive or more negative) in perceptions?

What more could, (or should) be done at this stage?

Take a few moments to summarise the main discussion and action points and check for consensuses.

Given all the questions and discussions so far:

- Is there a specific climate area that should be further developed?
- What 'tests of change' if any, could be made?

## Appendix K – Example improvement plan template

Concern raised	Action	Person responsible	Timescale





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