Survey 8969
(Preview)

Silence kills 2010 form a2

Story Collector Questions

Think of a time when you were using a safety tool (for example, the Universal protocol checklist, the WHO checklist, an SBAR handoff protocol, a drug-interaction warning system, or some other safety tool) and the tool worked. The tool warned you of a problem that otherwise might have been missed and harmed a patient.

1. Have you ever been in this situation—a situation when a safety tool warned you of a problem that otherwise might have been missed and harmed a patient? In other words, have you ever seen one of these tools work as intended?

- ◯ No, never
- ◯ Once or twice in my career
- ◯ Once or twice a year
- ◯ Nearly every month
- ◯ A few times a month
- ◯ A few times a week
- ◯ Every day

The hope is that when a safety tool works—when it warns about a potential mistake—the caregiver who gets the warning can speak up to the physicians and others involved, they will listen, and the problem will get solved. And yet caregivers tell us that getting the warning doesn't necessarily make it easy to speak up. Sometimes a caregiver or an organization's environment makes it feel unsafe to speak up.

2. Have you ever been in this situation: a tool warned you about a possible problem, but it felt unsafe to speak up and share your concerns?

- ◯ No, never
- ◯ Once or twice in my career
- ◯ Once or twice a year
- ◯ Nearly every month
- ◯ A few times a month
- ◯ A few times a week
- ◯ Every day

3. Have you ever been in a situation where a tool warned you about a possible problem, you spoke up, but others wouldn't listen or act on your concerns?

- ◯ No, never
- ◯ Once or twice in my career
- ◯ Once or twice a year
- ◯ Nearly every month
- ◯ A few times a month
- ◯ A few times a week
- ◯ Every day

4. Please describe a specific incident when a tool warned you about a possible problem, but it was either hard to speak up or hard to get others to listen and act. We want to understand what happened. Please relate this incident as if you were telling us the whole story from beginning to end. What kind of tool/checklist/ warning system were you using? What was the possible problem you discovered? Who did you need to convince and collaborate with to solve it? What did you do? How did they react? What made it difficult? What happened in the end? What conclusions did you draw as a result?

5. Please read over your story, and give it a title. The title should capture the essence of the incident.

6. Was this experience a one-time event, or is it part of a continuing pattern in how people treat each other in your work environment? Please use a scale from 1 to 10, where 1 means it was a one-time event and 10 means it is a part of a continuing pattern.

- 1 One Time Event
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10 Continuing Pattern

7. Was this experience isolated to only one part of your work life (for example, experienced with just one physician, one caregiver, one manager, one patient, or one kind of problem) or is it widespread across all areas of your work? Please use a scale from 1 to 10.

- 1 Isolated Incident
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10 Widespread across all areas of my worklife

8. When incidents like the one you just described happen, does it feel as if they are out of your control, or do you feel able to solve them or prevent them from happening again in the future? Please use a scale from 1 to 10.

- 1 Within My Control
- 2
- 3
- 4
- 5
- 6

- 7
- 8
- 9
- 10 Not Within My Control

9. Please think back over incidents like the one you described. Have these kinds of incidents resulted in near misses or actual patient harm in your area? Please check all that apply.

- [ ] No actual error, but potential for error.
- [ ] An error, but caught before any harm came to a patient.
- [ ] A patient was affected--but no harm.
- [ ] A patient was harmed--was at greater risk, had to spend more time in the hospital, required more attention from staff or physicians, or required a test--but no medication or treatment was required to counter the harm.
- [ ] A patient was permanently harmed.
- [ ] A patient nearly died.
- [ ] A patient died.

10. Please share one other story with us. Think of a time when you made a positive difference by speaking up. This could be a time when others would have let the situation slide, not recognized its importance, or felt unable to speak up—but you did, and it was important that you did. Describe this incident so we can understand the skills you used. Please relate this incident as if you were telling us the whole story from beginning to end. What was the possible problem you discovered? Who did you need to convince or collaborate with? What did you do? What was it that made you effective? What happened in the end? What conclusions did you draw as a result?

11. Please read over your story, and give it a title. The title should capture the essence of the incident.

12. Were your actions in this case a one-time event, or is it part of a continuing pattern in how you work with others in your work environment?

- 1 One Time Event
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10 Continuing Pattern

13. Were your actions in this case isolated to only one part of your work life (for example, possible with just one physician, one caregiver, one manager, one patient, or one kind of problem) or is it widespread across all areas of your work?

- 1 Isolated Incident
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10 Widespread across all areas of my worklife

14. When you take actions like the ones you just described, do you end up feeling out of control or do you feel you can make a difference?

- 1 Within My Control
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10 Not Within My Control

Healthy Work Environment Questions

15. Does your organization have a zero tolerance policy on abuse and disrespectful behavior?

- Yes, on both
- Yes, on abuse only, but not on disrespectful behavior
- Yes, on disrespectful behavior only, but not on abuse
- No
- Don't know

16. To what degree is abuse and disrespectful behavior toward RNs tolerated in your organization?

- Not at all tolerated
- Rarely tolerated
- Occasionally tolerated
- Frequently tolerated

17. If you work in a hospital, has that hospital earned Magnet recognition?

- Yes
- No, but the hospital is in the process of applying

- ◯ No
- ◯ Not sure
- ◯ Don't work in a hospital

18. If you work in a critical care unit, has your unit earned the AACN Beacon Award for Critical Care Excellence?

- ◯ Yes
- ◯ No, but the hospital is in the process of applying
- ◯ No
- ◯ Not sure
- ◯ Don't work in a hospital

19. If you work in a hospital, does your hospital have a shared governance program?

- ◯ Yes, a formal shared governance program is in place
- ◯ No, but the hospital is in the process of developing and implementing such a program
- ◯ No
- ◯ Not sure
- ◯ Don't work in a hospital

20. Please read the statements below, and check the ones that are true for your workgroup. Check all that apply.

- ☐ a. People here have the skills they need to intervene without being disrespectful.
- ☐ b. When someone wants to speak up about a concern, he/she can count on support from the people around them.
- ☐ c. Intervening when you disagree is clearly understood to be a part of your job here.
- ☐ d. Voicing your concerns is seen as a moral imperative here.
- ☐ e. Time outs, hand-off protocols, surgical pauses, checklists and other safety practices are used routinely here.
- ☐ f. People who are skilled at speaking up and holding others accountable are recognized and rewarded by the organization.
- ☐ g. When people here have a concern, they know how to politely get others to stop what they're doing and listen.
- ☐ h. The norm here is for people to hold each other accountable regardless of role or position.
- ☐ i. People take pride in their ability to speak up to others, regardless of their role or position.
- ☐ j. The physicians, managers, and other caregivers who work here expect you to speak up when you have a problem with something they are doing.
- ☐ k. The organization uses rewards and sanctions to encourage people to speak up and take action when they have a concern.
- ☐ l. There are specific times, places, and processes that make it easy for people to share their concerns.

Demographics

21. Your Level in the Organization

- ◯ First-level employee--no direct reports
- ◯ First-level supervisor--supervise first-level employees
- ◯ Second-level supervisor/manager--supervise first-level supervisors
- ◯ Above second-level supervisor/manager
- ◯ Physician
- ◯ Not applicable

22. Your Profession

- Nurse
- Physician
- Resident
- Medical Student
- Other Clinical Care Provider
- Administration
- Manager
- Other

23. Department or Unit where you work.

-- Select Answer --

24. Please select your age

- Less than 26 years old
- 26 -35 years old
- 36 – 45 years old
- 46 – 55 years old
- 56 – 65 years old
- More than 65 years old

25. Please select your years of experience in healthcare

- Less than 4 years
- 4 -6 years
- 7 – 10 years
- 11 – 15 years
- 16 – 25 years
- 26 - 35
- More than 35 years

26. Please select the state where you work

-- Select Answer --

27. Please indicate your sex

- Female
- Male