SAFE SURGERY 2015: SOUTH CAROLINA
Tool 2: Surgical Safety Culture Survey

A. Hospital name:

_____

B. Are you (or will you be) the person or one of the people responsible for checklist implementation in the ORs where you work?

01 ○ Yes
00 ○ No

C. What is your primary professional role?

01 ○ Surgeon
02 ○ Anesthesiologist
03 ○ CRNA
04 ○ Surgical nurse
05 ○ Physician assistant
06 ○ Surgical tech
07 ○ Perfusionist
08 ○ Intern/Resident/Fellow
99 ○ Other: _____

D. How many years have you worked in this role (at any hospital)?

01 ○ <1
02 ○ 1-5
03 ○ 6-10
04 ○ >10

E. In which surgical service(s) do you work? (Check all that apply.)

01 ☐ General
02 ☐ Trauma
03 ☐ Orthopedic
04 ☐ Neurosurgery
05 ☐ Cardiac
06 ☐ Thoracic
07 ☐ Vascular
08 ☐ Pediatric
09 ☐ ENT
10 ☐ Urology
11 ☐ Gynecology
12 ☐ Ambulatory
99 ☐ Other: _____

F. In which service do you work most often? (Check one.)

98 ○ N/A: No primary service
01 ○ General
02 ○ Trauma
03 ○ Orthopedic
04 ○ Neurosurgery
05 ○ Cardiac
06 ○ Thoracic
07 ○ Vascular
08 ○ Pediatric
09 ○ ENT
10 ○ Urology
11 ○ Gynecology
12 ○ Ambulatory
99 ○ Other: _____

G. Do you consider yourself Hispanic or Latino?

01 ○ Yes
00 ○ No
97 ○ Decline to answer
96 ○ Unknown

H. Which category best describes your race?

01 ○ American Indian or Alaska Native
02 ○ Asian
03 ○ Black or African American
04 ○ Native Hawaiian or Other Pacific Islander
05 ○ White
06 ○ Multiracial
97 ○ Decline to answer
96 ○ Unknown

I. Age:

01 ○ 18-25
02 ○ 26-35
03 ○ 36-45
04 ○ 46-55
05 ○ >55
97 ○ Decline to answer

J. Gender:

01 ○ Male
00 ○ Female
97 ○ Decline to answer

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	Strongly Disagree						Strongly Agree
1. In the ORs where I work, surgical team members are open to changes that improve patient safety, even if it means slowing down.	①	②	③	④	⑤	⑥	⑦
2. In the ORs where I work, the Joint Commission "Time Out" is used in every case by every surgical team.	①	②	③	④	⑤	⑥	⑦
3. In the ORs where I work, the Joint Commission "Time Out" was difficult to implement.	①	②	③	④	⑤	⑥	⑦
4. In the ORs where I work, surgical team members all agree on the importance of using checklists in surgery.	①	②	③	④	⑤	⑥	⑦
5. In the ORs where I work, interest in checklist implementation is limited to one profession (e.g., surgery, anesthesia, or nursing).	①	②	③	④	⑤	⑥	⑦
6. In the ORs where I work, I am encouraged to report any patient safety concerns I may have.	①	②	③	④	⑤	⑥	⑦
7. In the ORs where I work, it is difficult to discuss medical mistakes.	①	②	③	④	⑤	⑥	⑦
8. In the ORs where I work, surgical team members appear to struggle **and do not** ask one another for help.	①	②	③	④	⑤	⑥	⑦
9. In the ORs where I work, it is difficult to speak up when I perceive problems with patient care.	①	②	③	④	⑤	⑥	⑦

	Strongly Disagree						Strongly Agree
10. In the ORs where I work, team discussions (e.g., briefings or debriefings) are common.	①	②	③	④	⑤	⑥	⑦
11. In the ORs where I work, communication breakdowns frequently lead to delays in starting surgical procedures.	①	②	③	④	⑤	⑥	⑦
12. In the ORs where I work, surgical team members make sure their comments or instructions are heard.	①	②	③	④	⑤	⑥	⑦
13. In the ORs where I work, surgical team members share key information as it becomes available.	①	②	③	④	⑤	⑥	⑦
14. In the ORs where I work, surgical team members appear eager to help one another.	①	②	③	④	⑤	⑥	⑦
15. In the ORs where I work, physicians and nurses work together as a well-coordinated team.	①	②	③	④	⑤	⑥	⑦
16. In the ORs where I work, surgeons and anesthesia providers work together as a well-coordinated team.	①	②	③	④	⑤	⑥	⑦
17. In the ORs where I work, surgical team members from different disciplines **always** discuss patients' conditions and the progress of operations.	①	②	③	④	⑤	⑥	⑦
18. In the ORs where I work, plans for patient care are adapted as needed.	①	②	③	④	⑤	⑥	⑦
19. In the ORs where I work, physicians are **only** open to suggestions from other physicians.	①	②	③	④	⑤	⑥	⑦
20. In the ORs where I work, disagreements are resolved with an emphasis not on **who** is right but **what** is right for the patient.	①	②	③	④	⑤	⑥	⑦
21. In the ORs where I work, decision-making is shared among disciplines in response to changes in patients' conditions or issues that arise during operations.	①	②	③	④	⑤	⑥	⑦
22. In the ORs where I work, physicians are present and actively participating in patient care prior to skin incision.	①	②	③	④	⑤	⑥	⑦
23. In the ORs where I work, physicians maintain a positive tone throughout operations.	①	②	③	④	⑤	⑥	⑦
24. In the ORs where I work, surgical team members communicate with me in a respectful manner.	①	②	③	④	⑤	⑥	⑦
25. In the ORs where I work, my input about patient care is well received by other surgical team members.	①	②	③	④	⑤	⑥	⑦
26. In the ORs where I work, I am always treated as a valuable member of the surgical team.	①	②	③	④	⑤	⑥	⑦
27. In the ORs where I work, potential errors or mistakes are pointed out **without** raised voices or condescending remarks.	①	②	③	④	⑤	⑥	⑦
28. In the ORs where I work, surgical team members refer to each other by role instead of name (e.g., "Nurse" instead of "Dana").	①	②	③	④	⑤	⑥	⑦
29. In the ORs where I work, surgical teams **always** discuss the operative plan (i.e., more than the location of the incision and name of the procedure) before incision.	①	②	③	④	⑤	⑥	⑦
30. In the ORs where I work, for complex patients or cases, preoperative briefings **always** include planning for potential problems.	①	②	③	④	⑤	⑥	⑦
31. In the ORs where I work, postoperative debriefings **always** include a discussion of key concerns for patient recovery and post-op management.	①	②	③	④	⑤	⑥	⑦
32. In the ORs where I work, equipment issues or other problems discussed in postoperative debriefings are addressed in a timely manner.	①	②	③	④	⑤	⑥	⑦
33. I would feel safe being treated here as a patient.	①	②	③	④	⑤	⑥	⑦
34. If I were having an operation, I would want a surgical safety checklist to be used.	①	②	③	④	⑤	⑥	⑦
35. Pressure to move quickly from case to case gets in the way of patient safety.	①	②	③	④	⑤	⑥	⑦

■ Thank you for your time. ■

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