

AHRQ Safety Program for Surgery



Perioperative Staff Safety Assessment

Introduction

Problem Statement

One of the strongest determinants of safety culture is whether local and hospital leadership respond to staff patient safety concerns. Frontline providers understand patient safety risks in their clinical areas and have great insight into potential solutions to these problems. Your team needs to seek frontline providers' knowledge and use it to guide your safety improvement efforts.

Purpose of This Tool

The Comprehensive Unit-based Safety Program employs the Staff Safety assessment, often called the two-question survey. The Safety Program for Surgery has modified that tool for the surgical setting into the Perioperative Staff Safety Assessment (PSSA). The PSSA helps you access this wisdom by directly asking providers: How will the next patient be harmed in your unit? What do you think can be done to prevent this harm? How will the next patient develop a surgical site infection on your unit? What do you think can be done to prevent this surgical site infection?

Please Adapt This Tool

A team of clinicians designed this tool to assess practice variability in its perioperative area. Your team may want to add questions that are not included in this tool, and this tool may include questions your team does not need. Please modify this tool to best fit your team's needs.

How To Use This Tool

The Safety Program for Surgery team leader (or designee) should hand out the Perioperative Staff Safety Assessment tool to all clinical and nonclinical staff in the unit. It is strongly recommended that you administer the Perioperative Staff Safety Assessment tool at the end of the Science of Safety training session, but it could also be available for staff to complete at any time. Staff should be encouraged to provide as much detail as possible when answering the four questions. Assign the task of handing out and collecting the safety assessment. To encourage staff to report safety concerns, consider placing a collection box or envelope in an accessible location where staff can drop off completed assessments privately.

How To Use This Data

Group the safety assessment responses by commonly identified defects (such as communication, medication process, equipment failure, supplies, etc.). Summarize and prioritize the defects identified (e.g., what percent of total responses were related to communication?). If the investigation reveals variability in surgical care, your safety program team can use additional audit tools, such as the Learning From Defects Through Collective Sensemaking tool, to dig deeper into the care delivery system. Once defects have been clearly identified, you can design a quality improvement intervention to address them. You should also share investigation results monthly or quarterly with your frontline staff and operating room leadership (if they are not already part of your Safety Program for Surgery team) to raise awareness of ongoing quality issues. You can use the AHRQ Safety Program for Surgery Toolkit to guide your team through the quality improvement intervention design process.



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NAME (OPTIONAL)	
JOB TITLE	
DATE	
CLINICAL AREA	
ASSESS RISK FOR HARM	
Please describe how you think the next patient in your clinical area will be harmed.	
Please describe what you think can be done to prevent or minimize this harm.	
ASSESS RISK FOR SURGICAL SITE INFECTION	
Please describe how you think the next patient in the operating room will get a surgical site infection.	
Please describe what you think can be done to prevent this infection.	

Thank you for helping to improve safety in your workplace!

AHRQ Pub. No. 16(18)-0004-8-EF
December 2017