

# H-PEPSS

## Health Professional Education in Patient Safety Survey

### Instructions:

- ▶ The H-PEPSS questionnaire asks about:
  - clinical safety issues such as hand hygiene, transferring patients, medication safety)
  - system issues that effect safety such as aspects of the organization, management, or the work environment including policies, resources, communication and other processes
- ▶ The survey is seeking your perceptions and opinions only. There are no right or wrong answers. Indicate the extent to which you agree or disagree with each question statement. If you are unsure whether you agree or disagree, mark “neutral”.

### What do we mean by:

- ▶ **Patient Safety:** The pursuit of reduction and mitigation of unsafe acts within the health care system, as well as the use of best practices shown to lead to optimal patient care outcomes



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For information about or permission to use the H-PEPSS, please contact Professor Liane Ginsburg in the School of Health Policy & Management at York University at [lgins@yorku.ca](mailto:lgins@yorku.ca)

## SECTION 1: Learning about specific patient safety content areas

Here we ask about 7 areas that have to do with keeping patients safe. We would like to know about the extent to which you feel confident about what you learned in each of these areas. We ask you to think about both your classroom and clinical practice setting experiences—and evaluate them separately.

	strongly disagree	disagree	neutral	agree	strongly agree	don't know	strongly disagree	disagree	neutral	agree	strongly agree	don't know
	...in the classroom						...in clinical settings					
<b>Clinical safety: "I feel confident in what I learned about..."</b>												
1. hand hygiene	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. infection control	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. safe medication practices	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. safe clinical practice in general	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Working In Teams with Other Health Professionals: "I feel confident in what I learned about..."</b>												
5. team dynamics and authority/power differences	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. managing inter-professional conflict	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. debriefing and supporting team members after an adverse event or close call	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. engaging patients as a central participant in the health care team	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. sharing authority, leadership, and decision-making	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. encouraging team members to speak up, question, challenge, advocate and be accountable as appropriate to address safety issues	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Communicating Effectively: "I feel confident in what I learned about..."</b>												
11. enhancing patient safety through clear and consistent communication with patients	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. enhancing patient safety through effective communication with other health care providers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. effective verbal and nonverbal communication abilities to prevent adverse events	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Managing Safety Risks: "I feel confident in what I learned about..."</b>												
14. recognizing routine situations in which safety problems may arise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. identifying and implementing safety solutions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. anticipating and managing high risk situations	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Understanding Human and Environmental Factors: "I feel confident in what I learned about..."</b>												
17. the role of human factors, such as fatigue, that effect patient safety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. safe application of health technology	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. the role of environmental factors such as work flow, ergonomics, resources, that effect patient safety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Recognize, Respond to and Disclose Adverse Events and Close Calls: "I feel confident in what I learned about..."</b>												
20. recognizing an adverse event or close call	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21. reducing harm by addressing immediate risks for patients and others involved	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22. disclosing an adverse event to the patient	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23. participating in timely event analysis, reflective practice and planning in order to prevent recurrence	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	strongly disagree	disagree	neutral	agree	strongly agree	don't know	strongly disagree	disagree	neutral	agree	strongly agree	don't know	
	...in the classroom							...in clinical settings					
<b>Culture of safety: "I feel confident in what I learned about..."</b>													
24. the ways in which health care is complex and has many vulnerabilities (e.g. workplace design, staffing, technology, human limitations)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
25. the importance of having a questioning attitude and speaking up when you see things that may be unsafe	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
26. the importance of a supportive environment that encourages patients and providers to speak up when they have safety concerns	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
27. the nature of systems (e.g. aspects of the organization, management, or the work environment including policies, resources, communication and other processes) and system failures and their role in adverse events	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

## SECTION 2: How broader patient safety issues are addressed in health professional education

Please think about your health professional education overall (both classroom and clinical practice training) as you answer the following items.

	strongly disagree	disagree	neutral / unsure	agree	strongly agree
28. As a student, my scope of practice was very clear to me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
29. There is consistency in how patient safety issues were dealt with by different preceptors in the clinical setting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
30. I had sufficient opportunity to learn and interact with members of interdisciplinary teams	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
31. I gained a solid understanding that reporting adverse events and close calls can lead to change and can reduce reoccurrence of events	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
32. Patient safety was well integrated into the overall program	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
33. Clinical aspects of patient safety (e.g. hand hygiene, transferring patients, medication safety) were well covered in our program	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
34. "System" aspects of patient safety were well covered in our program (e.g. aspects of the organization, management, or the work environment including policies, resources, communication and other processes)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## SECTION 3: Comfort speaking up about patient safety

Now that you are working as a licensed health professional indicate how you currently feel about the following:

	strongly disagree	disagree	neutral / unsure	agree	strongly agree
35. If I see someone engaging in unsafe care practice in the clinical setting, I feel I can approach them	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
36. If I make a serious error I worry that I will face disciplinary action	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
37. It is difficult to question the decisions or actions of those with more authority	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
38. In clinical settings, discussion around adverse events focuses mainly on system-related issues, rather than focusing on the individual(s) most responsible for the event	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>