Site-Level Survey Data File Specifications
AHRQ Hospital Survey on Patient Safety Culture

Use these instructions if you are <u>submitting data from one or more hospitals</u>.

<u>INSTRUCTIONS:</u>

Step 1: Site-level data must be in Excel format (.xls, .xlsx). Please use the template provided.

Step 2: Include a header row with the variable name for each column.
Please include all variable names from the table below and ensure that each one is entered in the correct column. Failure to do so will result in delays in processing your data.

Step 3: Site ID(s) must match IDs in respondent-level data file.
Please enter a unique Site ID for each hospital. Make sure that each hospital's Site ID matches its Site ID in your respondent-level data file. This step is crucial for linking site-level and respondent-level data.

Step 4: File must contain one record for each hospital.
Enter each hospital in a separate row, including all required variables from the table below.

Step 5: Enter each hospital's Medicare Provider ID.
Please enter your Medicare Provider ID for each hospital.

Step 6: Enter each hospital's AHA ID, Bed Size, Ownership, and Teaching Status.
If your hospital is a Registered AHA Hospital, please enter the hospitals AHA ID. All hospitals must enter Bed Size, Ownership, and Teaching Status.

Column	Variable Name	Variable Label	Type	Details/Comments
Column A*	SiteID	Site ID	Numeric	Unique Site ID matching respondent-level data file.
Column B*	SiteName	Site Name	Character	Please use a unique name for each site.
Column C*	Address1	Street Address 1	Character	
Column D	Address2	Street Address 2	Character	
Column E*	City	City	Character	
Column F*	State	State	Character	2-character State abbreviation
Column G*	ZipCode	Zip Code	Character	5-digit zip code (include leading zeroes)
Column H	ZipPlusFour	Zip Code +4	Numeric	4-digit zip code extension
You must enter the name, phone number, and email of the contact person at each hospital.				
Column I*	Contact_First	Contact First Name	Character	
Column J*	Contact_Last	Contact Last Name	Character	
Column K*	Contact_Phone	Contact Phone #	Numeric	10-digit phone number with no spaces or dashes
Column L	Contact_Ext	Contact Extension	Numeric	Phone number extension
Column M*	Contact_Email	Contact Email Address	Character	

*Indicates required information for each hospital.

Column	Variable Name	Variable Label	Type	Details/Comments
*If a site does not have a *unique* AHA ID, then Bed Size, Ownership, and Teaching Status are required.				
Column N*	MedProvID	Medicare Provider ID	Character	6-character Medicare Provider ID (include leading zeroes)
*Column "O" AHA ID is required for all AHA Registered Hospitals.				
Column O	AHAID	American Hospital Association ID	Character	7-character AHA ID (include leading zeroes)
Column P*	BedSize	Bed Size	Numeric (1-8)	Please identify the total number of licensed beds in the hospital. 1. 6-24 beds 2. 25-49 beds 3. 50-99 beds 4. 100-199 beds 5. 200-299 beds 6. 300-399 beds 7. 400-499 beds 8. 500 or more beds
Column Q*	Ownership	Ownership	Numeric (1-4)	Please identify the type of organization that controls and operates the hospital. 1. Government non federal 2. Nongovernment not-for-profit 3. Investor-owned (for-profit) 4. Government, federal
Column R*	Teaching	Teaching Status	Numeric (1-2)	Please indicate whether your hospital is teaching or non-teaching. 1. Teaching 2. Non-teaching
Column S*	Denominator	Number of staff asked to complete the survey	Numeric	Must be 10 or more
Column T*	SurveyMode	Survey Mode	Numeric (1-4)	1. Paper 2. Web 3. Mixed Mode (paper & web) 4. Other
Column U*	StaffSurveyed	Staff Surveyed	Numeric (1-4)	Please indicated who the survey was administered to: 1. All staff/sample of all staff 2. Selected departments/units only (please specify) 3. Selected staff positions only (please specify) 4. Selected departments/units and selected staff positions (please specify)
Column V*	PleaseSpecify	Please Specify	Character (1000 max.)	If StaffSurveyed = 2, 3, or 4, please specify who the survey was administered to.
Column W*	EndMonth	End Month	Numeric (1-12)	Month of data collection completion
Column X*	EndYear	End Year	Numeric	Year of data collection completion (YYYY)

Column	Variable Name	Variable Label	Type	Details/Comments
Column Y *	TimesSurveyed	Including the data you are submitting, how many total times did you administer the survey since July 2011? **(Please only submit data from your most recent survey administration.)**	Numeric (1-3)	**1.** 1 time **2.** 2 times **3.** 3 times or more

*Indicates required information for each hospital.