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A PRESS GANEY SIGNATURE REPORT

# State of Healthcare Safety 2026

Safety is built on social capital, reinforced by leadership, and proven in performance. Data from 1.3 million employees and more than 23 million patients shows where healthcare safety stands today.

Dear colleagues,

Safety is healthcare's most sacred promise. A patient places their trust in a system they cannot fully see. A family assumes coordination behind the scenes. And every caregiver depends on the people and processes around them to ensure their safety, as well as the safety of the patient.

But I ask: Are we delivering?

In "**State of Healthcare Safety 2026**," we examine the latest national data and what it reveals about the state of safety across our industry. The findings show progress in key outcomes, even after years of profound volatility and strain. They also reveal areas of fragility—gaps in safety culture perceptions, after-hours vulnerabilities, exposure to workplace violence, and system breakdowns.

At its core, safety is grounded in trust and reinforced through continuous learning. When teams believe their voices lead to action, reporting grows stronger, improvement accelerates, and patients feel the impact. Technology and analytics can help us detect risk, but sustaining high reliability over time requires the integration of people, process, and technology—grounded in trust built through visible leadership, transparency, and follow-through.

The path to zero harm begins by taking a good, hard look in the mirror. Do leaders and front-line teams experience safety the same way? Are concerns translated into visible action? Is psychological safety as strong at 2 a.m. as it is at 2 p.m.? Through Press Ganey's Zero Harm 24/7 collaborative, we are calling on leaders to embed safety as a defining enterprise strategy—anchored in measurement and learning, strengthened by workforce trust, and sustained by visible leadership commitment at every level.

This is not a new ambition. It's a commitment many of us have been pursuing for years. We have clarity of data, and we know the strategies to accelerate our progress. Now we must have the urgency to act—for the sake of our patients and our workforce.

With respect,

**Tejal Gandhi, MD, MPH, CPPS**
Chief Safety and Transformation Officer
Press Ganey

# Executive summary

"First, do no harm." For centuries, this principle has guided medicine's moral contract. But safety is not assured, and preserved, by principle alone. Actions at the bedside are only as strong as the systems that support them. And that starts in the C-suite and in the boardroom.

Press Ganey's "**State of Healthcare Safety 2026**" report reveals a defining reality: Harm rarely begins with a catastrophic event. It begins with subtle shifts in culture, communication, reporting behavior, workforce stability, and social capital. These early signals—often dismissed as "soft" indicators—are, in fact, predictive measures of reliability and variation.

Drawing on national safety culture data, workforce engagement metrics, patient safety event reporting patterns, safety outcomes, and patient experience insights, this report maps the interconnected drivers of safety performance. It demonstrates that organizations with deep learning systems, strong reporting cultures, aligned leadership, and robust social capital consistently outperform when it comes to safety, quality, workforce stability, and patient trust.

## Key insights: What shapes, strengthens, and sustains safety

**Safety culture is a leading indicator of workforce stability.** Seven of the top 10 national key drivers of employee engagement are related to safety culture, placing it among the strongest engagement drivers in the industry. Following pandemic-era declines, safety culture scores have seen statistically significant improvement across "resources and teamwork" (+0.05), "prevention and reporting" (+0.03), "pride and reputation" (+0.02), and "overall safety culture" (+0.04). However, a substantial portion (46.6%) of the workforce still reports low safety culture perceptions. And perceptions of safety culture remain uneven by role and shift, with markedly lower ratings among clinical staff—particularly those who interact most frequently with patients.

**Active reporting means higher performance.** Facilities that report safety events at or above the expected rate in the Press Ganey High Reliability Platform™ (HRP) are more than 8x as likely to rank in the top quartile for employee–manager collaboration, learning from mistakes, teamwork within units, and perception of care quality.

**Strong learning systems and reporting cultures reinforce one another.** Organizations that excel in cause analysis rigor and action plan strength are more likely to sustain robust reporting environments, creating a virtuous cycle of visibility, accountability, and progress.

**Social capital is the connective tissue that brings everything together.** Social capital is the force multiplier behind safety performance. Organizations that lead on employees' responses to questions about respect and teamwork are 3x more likely to achieve top-quartile patient loyalty scores and 50–80% more likely to excel on key safety outcomes. Safety depends upon the trust, shared purpose, and relationships that connect people across teams and roles. When those relational bonds are strong, engagement increases and reporting improves—and reliability follows.

**Safety suffers when a single organization operates as three hospitals under one roof.** Many organizations struggle with consistency of experience depending on shift resulting in what seems to employees and patients like three hospitals under the same roof. Staff perceive safety culture differently and patient experience of care varies based on shift—day, night, or weekend. This variance between days vs. nights and weekends can lead to more safety events and patients feeling less safe.

**Learnings come from the PSO.** Learnings from the Press Ganey Patient Safety Organization (PSO) can be leveraged to understand how and when harm occurs across the industry based on trending data. The members of the PSO gather insights from the more than 190 health system partners and 7.1M patient safety event records in its national database. For example, the PSO has taken a deep dive into diagnostic safety events (one of the most frequently occurring and harmful events) to identify themes and causal factors.

## Social capital is the foundation of reliability

Emerging AI-enabled tools, like the AI-powered Safety Coach in Press Ganey's High Reliability Platform can act as enablers for front-line leaders—helping to surface risk patterns and strong actions, prompt response and follow-up, and support consistent communication within and across teams. But, while technology can accelerate performance, the differentiator remains social capital: the strength of relationships that enable teams to learn together, adapt quickly, and maintain reliability, even under intense pressure.

The strength of social capital has far-reaching effects. Culture within echoes beyond the four walls, becoming the experience patients feel in every interaction. Top-performing units on "my work unit works well together" are 1.9x more likely to earn top scores on "rate the hospital 0–10." The impact is even stronger where trust is high: Units that lead on "there is a climate of trust within my work unit" are 2.4x more likely to achieve top scores on the item.

A climate of trust has an impact on patient experience results: High-performing units are 2.3x more likely to have patients report being treated with courtesy and respect, and 2.1x more likely to have patients feel that staff worked well together on their behalf. In short, the strength of relationships within teams inspires confidence among the patients they care for. And the #1 driver of patient "Likelihood to Recommend" (LTR) scores is simple: "The care team worked well together to care for me."

The same relational strength shows up in safety scores. Organizations in the top quartile on teamwork are 50–80% more likely to be top performers on key measures in the National Database of Nursing Quality Indicators® (NDNQI®), including for pressure injuries, CLABSI, and CAUTI.

This is all to say, social capital is not an abstract concept. Its impact on safety, quality, and experience metrics is quantifiable and significant.

Organizations in the top quartile on employee perception of teamwork are **50–80%** more likely to be top performers on key NDNQI measures.

## The hidden infrastructure of safety

Organizations that intentionally build social capital—achieved through efforts to align behavioral norms to enterprise values and ensure cultures of trust and belonging—create the conditions where safety, engagement, and experience mutually reinforce one another. Those with strong social capital consistently demonstrate higher engagement and lower burnout. Among organizations in the top decile for employee engagement, three of the five largest performance differentiators are related to respect, trust, and confidence in senior leadership.

Two factors play an outsized role in strengthening this relational infrastructure: leadership visibility and open communication. Units reporting strong alignment between front-line staff and senior leaders demonstrate stronger reporting cultures and higher performance on safety outcomes.

Psychological safety—the belief that it is safe to raise concerns without fear of blame—further amplifies this effect. When employees see reported concerns leading to action, reporting increases, learning accelerates, and trust deepens.

Put social capital to work. Download Press Ganey's ebook: "Activating your social capital strategy."

**Social capital has a night-shift stress test**

Night-shift employees are 17% less likely to believe their organization cares about their safety, and 11% less likely to feel leadership collaborates to ensure safe conditions—signals of weakened trust and confidence in leadership, when leaders are least present.

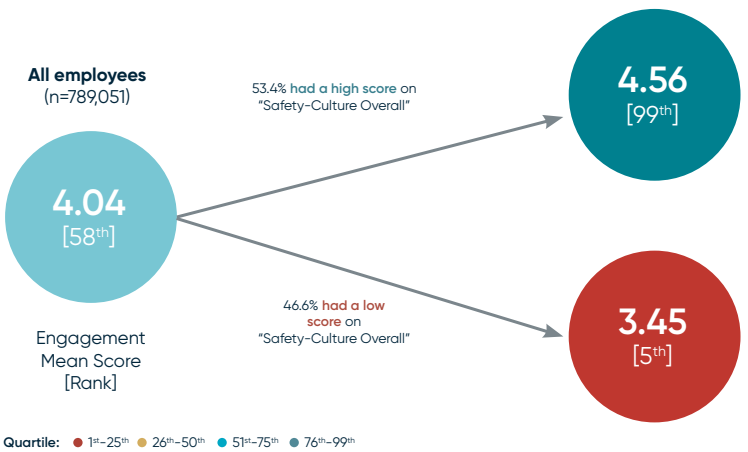
# Early warning signs of a system at risk

Safety problems begin well before serious events occur. They begin with subtle signals. Shifts in safety culture, workforce perceptions, reporting behavior, and exposure to workplace violence are all leading indicators of increased risk. Surveys that evaluate degrees of trust, psychological safety, teamwork, and confidence in leadership should not be treated as soft culture metrics. On the contrary, they are important indicators of operational reliability.

## The safety–retention connection

Perceptions of safety are strongly linked to employee engagement: Seven of the 10 strongest drivers of employee engagement are directly tied to safety culture, spanning both employee and patient safety. When employees believe their organization prioritizes safe working conditions, teamwork, and accountability, engagement rises. When those perceptions deteriorate, so does retention. Employees with unfavorable views of safety culture are 1.74x more likely to leave than those with neutral or favorable perceptions. In other words, safety culture isn't peripheral to employee engagement. In fact, it defines it.

## Perceptions of safety culture are strongly related to engagement



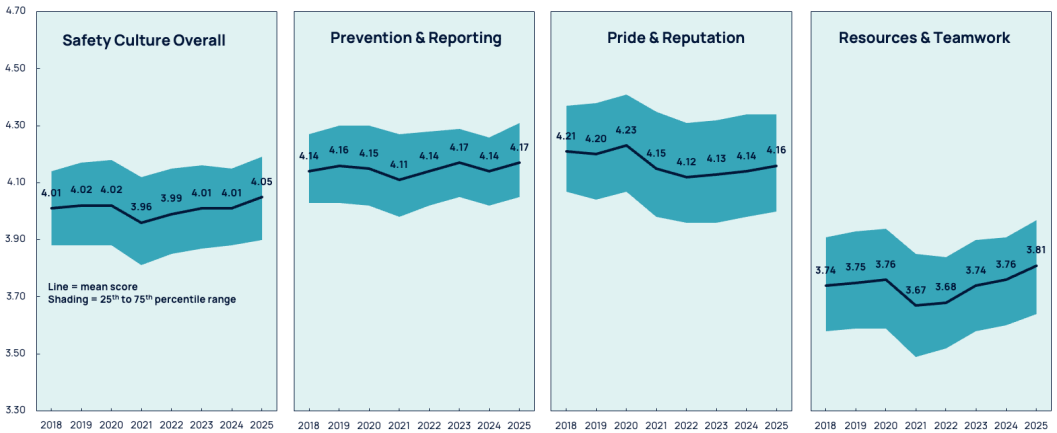

46.6% of employees give their organization a low score on overall safety culture.

Engagement is closely tied to whether employees believe their organization prioritizes their safety and that staff and management work together to maintain it. The strong correlation (0.76 for both items) shows that employees see safety as a proxy of organizational integrity. When systems are reliable, hazards are addressed, and leaders demonstrate their shared responsibility for safe environments, employees view this as proof that the organization stands behind its commitments. That credibility, in turn, strongly influences engagement.

This connection has direct implications for workforce stability, as disengaged employees are 2.6x more likely to leave than their highly engaged peers. When safety culture erodes, turnover risk rises—and with it, the potential for operational drift, variability in care, and weakened team cohesion.

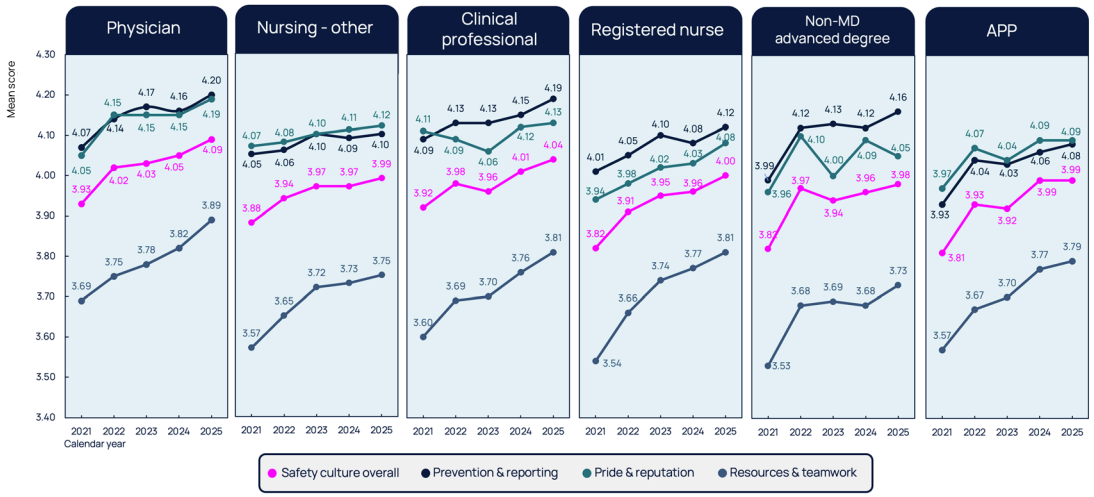
Following pandemic-era declines, 2025 saw statistically significant gains in perceptions of safety culture across all major dimensions. The most notable increases are in resources and teamwork (+0.05)—including staffing adequacy, cross-unit collaboration, and communication. Improvements are also evident in "prevention and reporting" (+0.03), "pride and reputation" (+0.02), and "overall safety culture" (+0.04), signaling renewed confidence in learning systems and organizational commitment to safety. However, 46.6% of respondents still perceive a low safety culture, indicating an immense opportunity for improvement across the industry.

## Perceptions of safety culture have increased, with many areas rising to pre-pandemic levels or higher




Looking at trends by clinical role reveals differences in perception and gains. While most roles show gradual improvement across dimensions—particularly in prevention and reporting and resources and teamwork—perceptions of safety culture among advanced practice providers (APPs) have plateaued, with scores overall holding flat at 3.99 year over year. Notably, "pride and reputation" among APPs has also leveled off (4.09). The only YOY decline appears among non-MD advanced degree clinicians in "pride and reputation" (4.09 to 4.05). While this dimension has been more volatile, historically, for the group, any downward movement warrants attention, given its close link to engagement and retention.

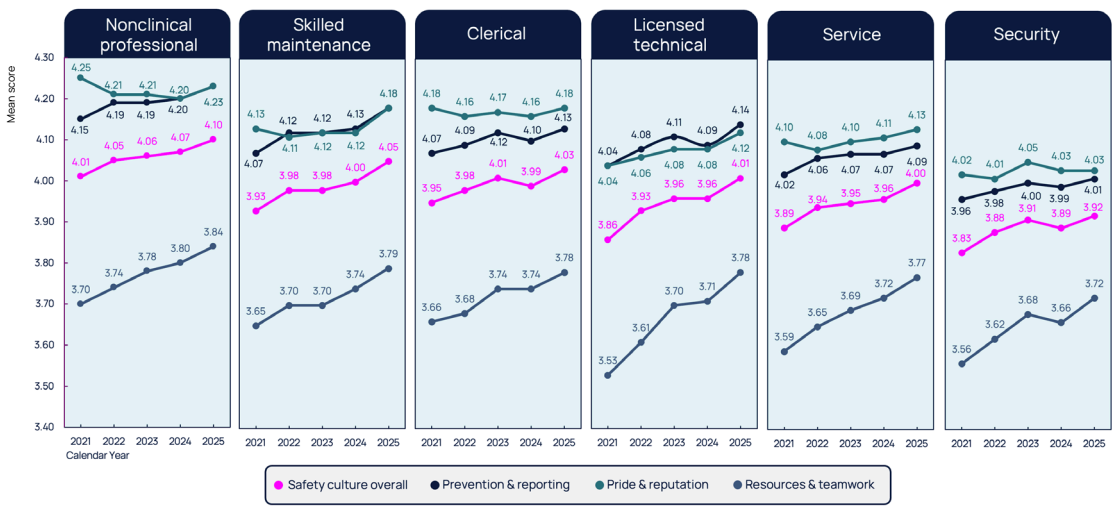
## Safety culture by clinical role




For leadership and nonclinical roles, the data is more encouraging. The only role to remain flat YOY is security personnel in the "pride and reputation" domain (4.03).

At the same time, this relative stability among leadership roles also surfaces a critical dynamic: Leaders tend to report stronger perceptions of safety culture than front-line staff. When executive confidence in safety exceeds the lived experience of nurses, APPs, and other caregivers, blind spots can emerge—undermining psychological safety, slowing reporting, and masking operational drift. One of the core objectives of Press Ganey's Zero Harm 24/7 collaborative is to close this perception gap, ensuring that leadership impressions and front-line realities are in sync.

## Safety culture by other role



## Safety culture by leadership role

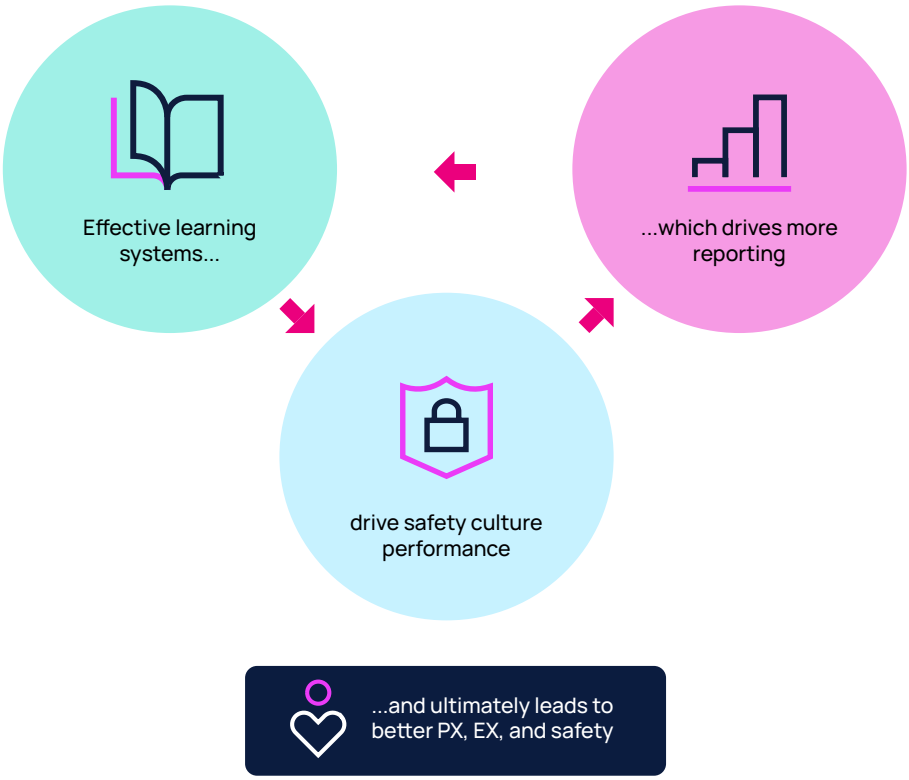

These shifts, while subtle, are not insignificant. Reporting, pride, reputation, resources, teamwork, and confidence in leadership are demonstrably connected to employee performance and retention. When perceptions flatten—or, worse, decline—organizations risk dampening engagement momentum. Sustaining safety culture progress, therefore, requires targeted leadership attention to role-specific signals before stagnation becomes drift.

**Shift trends tell a more nuanced story**

Safety culture scores improved across most roles in 2025, reflecting broad progress in engagement and learning. Much of that upward momentum is driven by day-shift employees, who saw the strongest gains (+0.04). Night-shift staff also improved, but only incrementally (+0.01), and they continue to report the lowest overall safety culture scores (3.90). Progress is real, but not evenly distributed.

## The importance of a strong learning system

Historically, the healthcare industry has used incident reporting systems as a warehouse for patient safety event data. Too often, however, these systems have become a black hole, where those who report safety events never hear what actions an organization has taken in response. Without follow-up, employees lose confidence that reporting leads to learning and real improvement, and safety culture erodes as a result.




Strong learning systems depend on robust reporting environments—leading to a flywheel effect where each strengthens the other. It is with this understanding that Press Ganey built the High Reliability Platform (HRP)—to eliminate the "black hole" of reporting dynamics and ensure reporting creates momentum for improvement. Rather than focusing solely on event reporting and volume, HRP measures the health of the learning system itself—tracking culture, lag time, root cause analysis quality, and action planning strength to drive continuous improvement. Press Ganey is introducing industry-leading safety learning system baseline measures and comparative benchmarks—shifting the focus from counting events to strengthening the system designed to prevent them.

| HRP learning system metric | Definition | 2025 average | Top-quartile threshold | Top-10% threshold |
|---|---|---|---|---|
| **Safety event reporting culture metrics** | | | | |
| Anonymous reporting rate | The rate at which patient safety events are reported by the workforce anonymously. A metric used to gauge psychological safety and safety culture. | 6% cases reported anonymously | 2.8% | 2.1% |
| Feedback rate | The rate at which total cases include documented feedback relative to the total volume of cases. Use the trend data to observe responsiveness to case information over time. | 8% cases include documented feedback | 14.3% | 23% |
| **Lag metrics** | | | | |
| Report lag | Measures the number of days between the date an event occurred and the date on which the event is reported. Monitor over time to ensure timely reporting. | 2.35 days | 1.55 days | 0.52 days |
| First review lag | Measures the number of days between the date an event occurred, and the date events are reviewed by the reporter's leader. | 5.08 days | 3.66 days | 2.48 days |
| Triage lag | The number of days between the date an event occurred and the date a leader/manager is assigned to review a case. | 9.02 days | 5.7 days | 3.98 days |
| Analysis lag | The number of days between an RCA start date and RCA complete date. | 20.41 days | 13.01 days | 4.36 days |
| Closed lag | The number of days between the date an event occurred and the case being closed (first lock date). | 32.98 days | 17.78 days | 10.6 days |

| Cause analysis metrics | | | | |
|---|---|---|---|---|
| Learning rate | The rate at which proximate causes are identified within the RCA process. This metric is used to measure how thoroughly and efficiently RCAs are being performed. | 5.61 proximate causes | 9.27 proximate causes | 17.16 proximate causes |
| Root cause analysis per serious safety event rate | The rate at which Root Cause Analyses are created per Serious Safety Event (SSE). | 0.415 RCAs for every SSE in the data set | 0.98 RCAs for every SSE in the data set | 1.87 RCAs for every SSE in the data set |
| **Action planning metrics** | | | | |
| Action plan completion rate | The proportion of completed actions relative to all submitted actions, serving as an indicator of accountability and follow-through. | 56.7% completed actions | 65% completed actions | 86% completed actions |

**Reliability doesn't end at 5 p.m.**
A learning system has to work after hours, too. Night-shift employees are 12% less likely to feel like mistakes lead to learning—not blame—than day-shift employees. This is a call to action for leaders to elevate psychological safety, closed-loop learning, and reporting systems for the night shift.

## Stronger learning. Safer culture. Better experience.

Facilities with safety event reporting volumes at or above expected rates consistently outperform across key culture and experience measures. For instance, organizations at or above the expected reporting rates are more than 8x as likely to rank in the top quartile on core safety culture items:

- 9.1x stronger employee–manager collaboration for safety
- 8.4x more frequent learning from mistakes
- 8.3x stronger teamwork within units
- 8.2x higher perception of care quality

High-reporting facilities also demonstrate stronger performance across key learning system measures. They are:

- 3.4x more likely to be a top performer on "strength of backlogged action items per serious safety event"
- 2.2x more likely to be a top performer on "strength of completed action items per serious safety event"
- 1.7x more likely to be a top performer on "cause analysis per serious safety event"
- 1.7x more likely to be a top performer on "root cause analysis per serious safety event"

The relationship is reciprocal. Organizations that conduct more rigorous and consistent investigations following serious safety events are more likely to have strong reporting cultures—33% more likely for root cause analysis per serious safety event and 19% for cause analysis.

The pattern extends to patient experience. Facilities where staff members report more events have stronger performance on patients' perception of hospital cleanliness (2.5x), teamwork among staff (2.1x), communication about new medications (2x), and attention to patient needs and discharge support (1.4x).

Facilities where staff members report more events are doing so much more than checking boxes. They're building cultures of learning, transparency, and continuous improvement—cultures that translate directly into better outcomes for patients and caregivers alike. Importantly, organizations that integrate safety learning into daily operations—rather than treating it as episodic or compliance-driven—can also predict performance in safety perception.

**Safety at scale: The Press Ganey PSO**

Press Ganey's Patient Safety Organization (PSO) is the largest in the country, powered by patient safety event reports from 4,500+ facilities, which have contributed more than 7.1M safety events since 2016. The breadth and depth of industry-wide reporting give health systems unmatched visibility into safety trends and causal factors. Members benefit from legally protected data sharing, peer benchmarking, AI-assisted event classification, and expert guidance that turn reporting into actionable learning. By advancing comparative insights and real-world learning loops, the PSO helps organizations strengthen safety culture, improve reliability, and accelerate progress toward zero harm. Learn more here.

## Where harm concentrates

Safety event distribution reveals specific areas of vulnerability. Over half of all safety events in the PSO fall into four categories:

- Care management
- Medication event
- Procedural
- Delays in diagnosis or treatment

These patterns point to recurring breakdowns in everyday clinical workflows—not rare or highly specialized failures, but routine processes where reliability is most critical.

Root cause analysis data for diagnostic safety events (e.g., missed diagnosis, delayed treatment) reveals the most common individual failures that lead to those events: failure to validate and verify—like failing to recheck test results—and incorrect assumptions, such as anchoring on early impressions without ruling out other possibilities or considering a full differential diagnosis (both 12%).

These cognitive errors often coincide with system-level breakdowns, such as insufficient safeguards and missed actions—essential workflow steps that were either poorly executed or not completed at all. This root cause analysis data suggests that people aren't necessarily doing the *wrong* thing; they are failing to do something that should have been done. In other words, instances of delayed treatment are primarily driven by errors of omission vs. errors of commission. These events reflect both cognitive error and workflow gaps, highlighting the need for safeguards that strengthen clinical reasoning and ensure critical steps aren't missed.

**Organizational reflexes**

The strength of a safety culture is reflected in how an organization responds to early warning signs of harm. Strong systems develop reflexes—habits of noticing, reporting, learning, and adapting before harm escalates. Ask:

- Do leaders detect risk early?
- Do employees feel safe reporting it?
- Does learning actually change practice?
- Are changes communicated back to the team?
- How often are safety events reported anonymously?
- Is AI used to anticipate where future events are likely to occur?

# When risk becomes reality

If leading indicators reveal where risk is building, lagging indicators show where harm has already occurred. Measures like safety event reports, traditional safety outcome metrics, and even patients' perceptions of safety may be the datapoints leaders most readily recognize, but they surface only after breakdowns have materialized in care delivery.

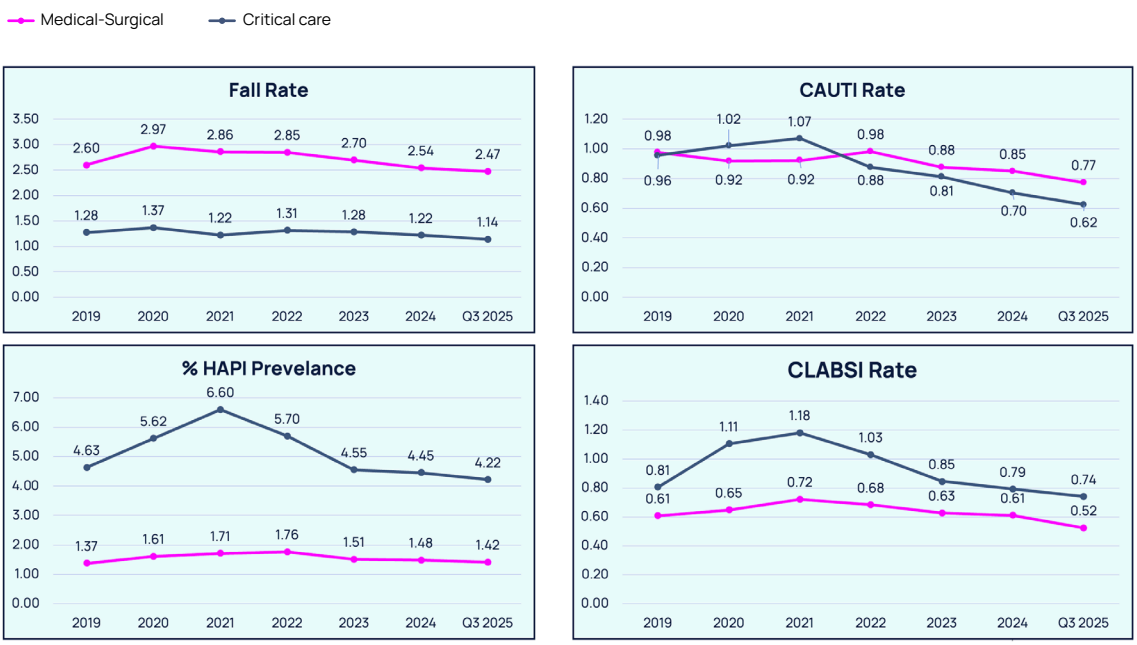
Understanding how these outcomes move—and how they connect back to culture, workforce stability, and patient experience—enables leaders to recognize warning signs early and address them proactively.

## Safety outcomes trending in the right direction

Across critical care and medical-surgical units, safety outcomes show positive performance following mid-pandemic peaks. While several measures worsened between 2019 and 2021—most notably HAPI prevalence, which rose from 2.52 in 2019 to a high of 3.43 in 2021—all four indicators have improved steadily since.

By Q3 2025, fall rates decreased to 2.03 (down from 2.16 in 2019), HAPI prevalence fell to 2.40 (from 2.52), CAUTI rates dropped to 0.72 (from 0.97), and CLABSI rates declined to 0.60 (from 0.68).

## NSI trends in critical care and medical-surgical units



There is a clear and measurable connection between responsiveness, teamwork, and fall outcomes. Units that are top performers on the patient experience question "received help as soon as needed" are 1.6x more likely to be top performers on injury fall rates. The difference is clinically meaningful: Bottom-performing units on responsiveness see injury fall rates 50% higher than top-performing units (0.60 vs. 0.40). Units that excel on "help toileting as soon as you wanted" are 1.4x more likely to be top performers on total fall rates, with bottom-performing units experiencing 38% higher fall rates than top performers (2.38 vs. 1.72, respectively).

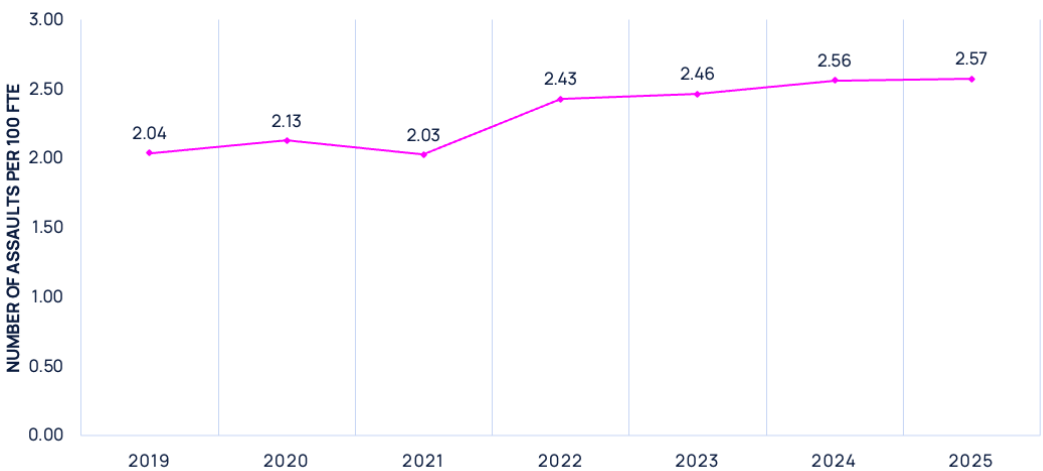
Teamwork shows an equally powerful relationship. Units that are top performers on "staff worked together" are 1.4x more likely to be top performers on total fall rates. In contrast, total fall rates are 19% higher in units that score lowest on teamwork (2.19 vs. 1.84).

Patient experience indicators like responsiveness and teamwork—together with top performance on safety and quality measures—are signs of clinical reliability. Further, when patients perceive well-coordinated help and care, their trust in the system is reinforced, and loyalty follows.

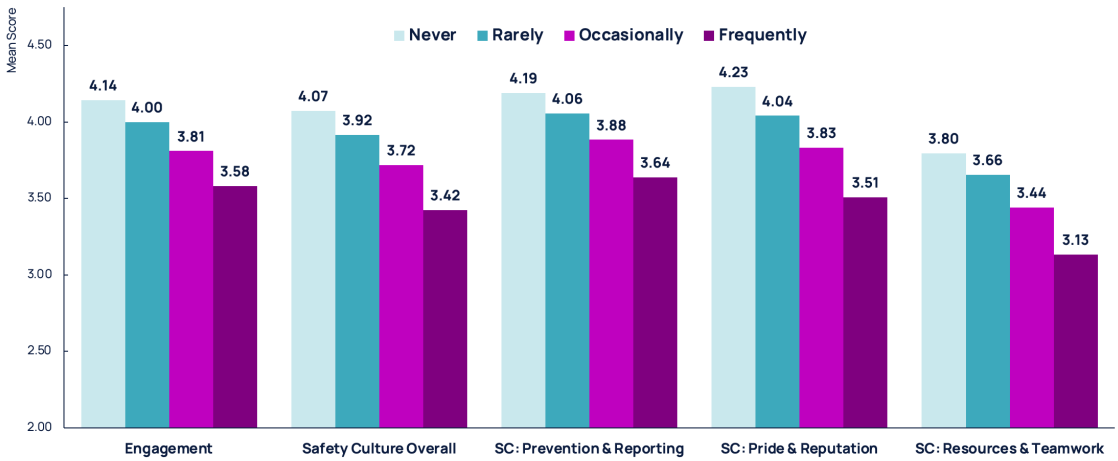
## Hazards on the front lines: Workforce safety is a precondition to patient safety

Reported assaults on nurses have increased steadily year over year—aside from a brief decline during the early pandemic period. After dipping from 2.13 per 100 full-time equivalents (FTEs) in 2020 to 2.03 in 2021, rates resumed their upward trajectory. In 2025, reported assaults reached 2.57—an uptick from 2.56 in 2024 and markedly higher than the 2019 baseline of 2.04. This trend is consistent across care environments, with annual assault rates rising at nearly identical levels in units with and without psychiatric settings.

### Annual assaults against nursing personnel per 100 FTEs



## Those who experience violence from patients or families are less engaged, and have lower perceptions of safety culture




Leaders must embed patient safety and workforce safety as core organizational values, governed by the principles of high reliability. And they must treat both as equally essential—because protecting caregivers and patients is the foundation of sustained safety performance.

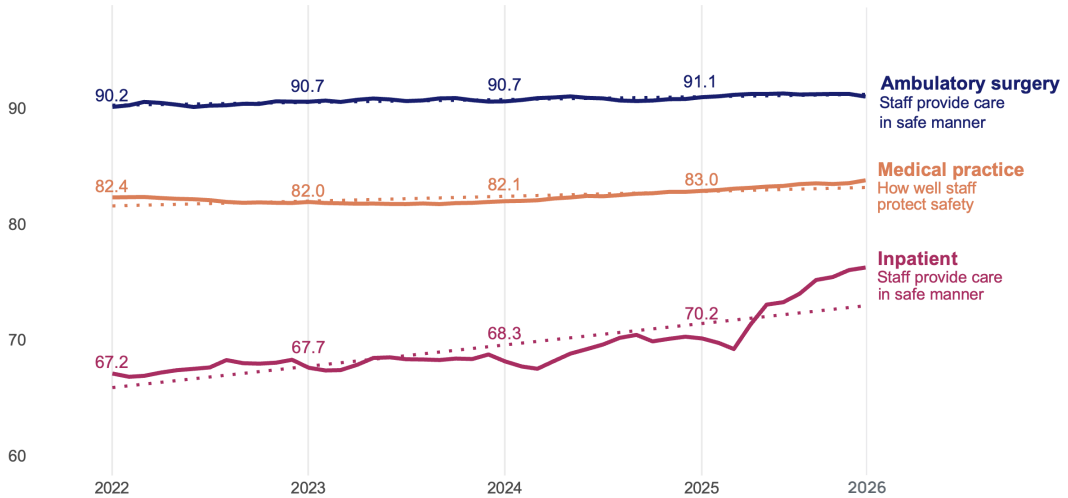
### Night shift bears the brunt of violence

Violence in care settings undermines both engagement and safety culture—whether employees experience it directly or witness it. Those exposed to violence report lower engagement and weaker perceptions of safety, with night-shift staff bearing a disproportionate burden: They are 3x more likely to report frequently witnessing violence and 4x more likely to report frequently experiencing it from patients or families.

## Bridging experience and excellence, trust and loyalty

Patient perceptions of safety strengthened across every major care setting in 2025—a positive signal for healthcare leaders focused on building high reliability systems. Inpatient settings saw the most meaningful gains, with scores rising +3.9 points year over year. In the medical practice, scores improved by +0.9, while ambulatory surgery increased +0.4. Though progress is evident across the continuum, the magnitude of improvement varies, suggesting different operational pressures and opportunities by setting.

## Yearly patient perceptions of safety trends




In medical practice, safety perceptions improved across all age groups. However, younger patients (ages 18–34) continue to report the lowest baseline perceptions of safety and saw the smallest YOY gain (+0.2). This persistent gap underscores the need to better understand how younger patients define and evaluate safety, particularly as expectations around communication, transparency, and responsiveness rise.

Importantly, patients' perceptions of safety are tightly linked to their loyalty. Patients who gave optimal (top-box) responses to safety-related questions were significantly more likely to recommend across settings: 2.1x more likely in medical practice, 2.5x in ambulatory surgery, and 2.7x in inpatient settings. As safety perception rises, so does trust—and with it, advocacy. In 2026 and beyond, organizations that treat safety not only as a clinical imperative but as a strategic experience driver will be best positioned to strengthen both outcomes and brand reputation.

## Conditions that shape safety

Across inpatient and emergency department settings, infrastructure—not just clinical complexity—plays a meaningful role in how patients experience care, and how employees feel delivering it. Variations in staffing models, leadership presence, tenure mix, communication patterns, and exposure to workplace violence shape both perception and performance—often in ways that traditional clinical metrics fail to capture.

### After hours, experience gaps emerge

- **Emergency department patient experience varies significantly by time of day.** Evening and night patients are more likely to leave negative comments related to access, safety, and environment.
- **65.6% of evening-shift ED comments reference staff—and 26% of those comments are negative.** This indicates heightened sensitivity to staffing, communication, and coordination after hours.
- **Inpatient weekend discharges are associated with weaker perceptions of care coordination, discharge communication, and responsiveness.** Surgical patients show especially pronounced gaps.
- **Teamwork scores drop after hours.** Evening ED patients score 1.69 points lower on "staff worked together" compared to day-shift patients; night-shift patients score 1.34 points lower.

These differences persist even when controlling for demographics, admission type, and length of stay—indicating that timing and operational context materially shape patient perceptions.

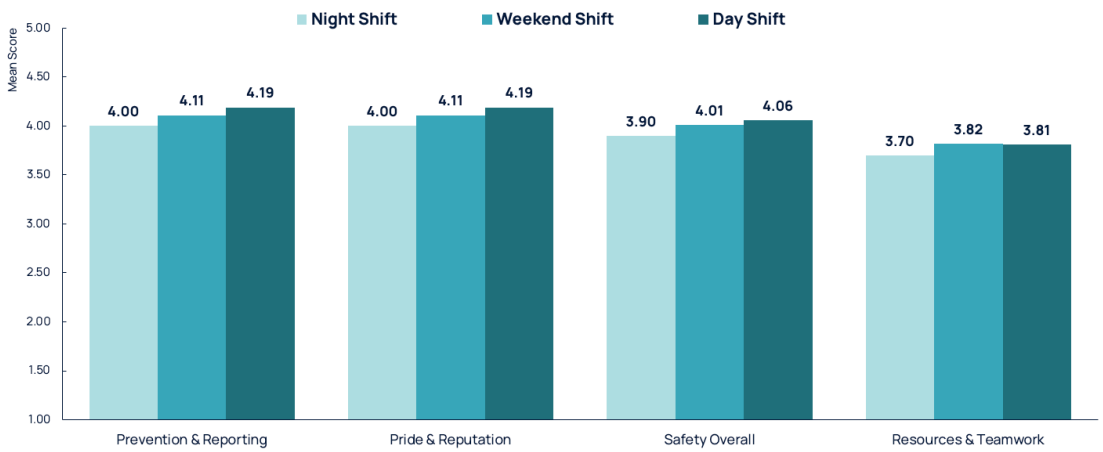
To ensure patients feel safe and supported 24/7, organizations must intentionally focus on workforce communication, teamwork, and reliability during nights, weekends, and other high-risk transitions—i.e., precisely when both patients and staff are at their most vulnerable.

**Zero Harm 24/7: A leadership mandate**
Zero Harm 24/7 is a national initiative calling on healthcare CEOs and boards to accelerate progress toward eliminating preventable harm—every day, everywhere, for everyone. Grounded in Press Ganey's safety culture data and powered by the nation's largest Patient Safety Organization and safety benchmarking database, the movement focuses on embedding safety into governance, leadership, and daily practice. Learn more here.

## Workforce impact and experience risk

Safety and experience gaps after hours are not only a patient phenomenon, but they're deeply connected to workforce realities. Employees working nights report systematically lower perceptions of safety culture across every measured dimension compared to their day-shift peers, with the most pronounced gaps in "pride and reputation" and "prevention and reporting" (both 0.19). These findings suggest that off-hours staff may feel less supported, less connected, and less confident in the organization's reliability—conditions that can exacerbate burnout and quietly shape how care is delivered.

## Night shift has lower perceptions across all areas of safety culture, compared to the day shift




To create a consistent safety culture and eliminate the experience of three hospitals under one roof, there is a clear set of needs:

- More visible and responsive leaders during overnight and weekend hours—leaders who close the loop on issues instead of letting them linger
- Clearer handoffs between all shifts
- Stronger physician–nurse collaboration
- Security presence and clear, zero-tolerance policies for workplace violence
- Standardized, core tenets of an optimal practice environment: adequate tools, functioning equipment, and the resources needed for all staff to do their jobs well

## Pitfalls of 3 hospitals under one roof

The data shows meaningful differences in perceptions of safety culture between shifts, with the largest gaps between the two groups that make up the majority of our workforce: day and night shift. Employees working nights report systematically lower perceptions of safety culture across every measured dimension compared to their day-shift peers, with the most pronounced gaps in "pride and reputation" and "prevention and reporting" (both 0.19). These findings suggest that off-hours staff may feel less supported, less connected, and less confident in the organization's reliability—conditions that can exacerbate burnout and quietly shape how care is delivered.

Weekend shift falls in the middle. While those employees generally align more closely with the day shift on "resources and teamwork," they do fall below day shift in certain areas—particularly "prevention and reporting" and "pride and reputation"—indicating that some of the pressures associated with reduced staffing or limited real-time support extend into weekend operations as well. Even so, their perceptions remain consistently above the night shift, reinforcing the pattern that night shift stands apart as the most challenged group.

Taken together, these differences create what is effectively three hospitals under one roof:

- A day-shift experience that is consistently strongest
- A weekend-shift experience that is slightly less supported but still aligned
- A night-shift experience that is materially more challenged across the board

This segmentation underscores that the safety culture is not uniform: Employees' lived experience varies dramatically based on when they work, with those on the night shift most in need of targeted support and connection.

### The night-shift effect

The widest gaps between day and night shifts reflect differences in how safe, supported, and trusted employees feel. The following items highlight where perceptions diverge most significantly.

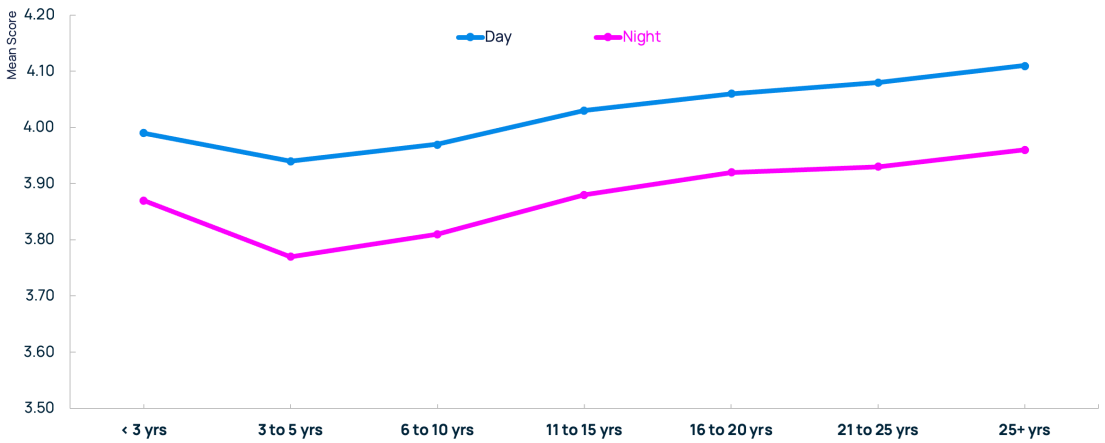
1. This organization cares about employee safety
2. Employees and management work together to ensure the safest possible working conditions
3. When a mistake is reported, it feels like the focus is on solving the problem, not writing up the person
4. Senior management provides a work climate that promotes patient safety
5. My work unit is adequately staffed
6. This organization supports me in balancing my work and personal life
7. I can report patient safety mistakes without fear of punishment
8. I am involved in quality improvement activities
9. This organization makes every effort to deliver safe, error-free care to patients
10. I have the tools and resources I need to do my job well

## Who works the night shift—and why it matters

The night-shift workforce skews heavily toward newer employees. More than half of night-shift staff (51%) have been with their organization for less than three years, vs. 36% on the day shift. In contrast, long-tenured employees are far less represented overnight: Only 11% of night-shift staff have over 15 years of service, vs. nearly 20% on days. Evening and weekend shifts fall somewhere in between but still lean towards a shorter tenure.

But tenure doesn't fully explain the experience gap. Regardless of length of service, employees working nights consistently report lower levels of engagement than their peers on other shifts.

## Regardless of length of service, night shift has consistently lower perceptions of safety, compared to other shifts




Across every shift, the message from the workforce is strikingly consistent. The top five themes—staffing and workload, compensation, communication, interdepartmental collaboration, and leadership effectiveness—dominate employee feedback. But the night shift tells an even more urgent story: Those employees are 2x as likely to raise concerns about safety and security.

## Strategic imperatives for executive leadership

**Safety must be both an outcome and a strategy.** And it begins upstream—in leadership decisions, governance priorities, workforce stability, and the systems that convert reporting into learning. When those foundations weaken, harm follows. When they strengthen, reliability compounds, and trust takes hold.

**Invest in social capital as a safety strategy.** Respect, trust, and teamwork—the core currencies of social capital—are predictors of both safety outcomes and patient loyalty. Organizations that cultivate strong bonds within and across teams see measurable and sustained improvements in employee engagement, reporting, and safety events. Leadership development, rounding, and open communication are not cultural "nice-to-haves." Rather, they are structural enablers of high reliability.

**Elevate safety to the board level.** Safety must be a board imperative and highly visible in board discussions, executive performance goals, and enterprise strategy. Real progress requires alignment between governance, front-line practices, and learning systems—and a clear understanding of how safety culture connects to employee engagement, patient experience, and clinical outcomes. When safety culture strengthens, engagement rises. When engagement rises, teamwork and reporting improve. And when those improve, outcomes follow, and performance becomes more resilient and sustainable under pressure in the continued pursuit of Zero Harm 24/7.

**Get ahead of harm with cutting-edge technologies.** Predictive analytics and integrated experience platforms can surface emerging vulnerabilities across workforce sentiment, reporting lag, and patient experience trends before they escalate into harm. When deployed thoughtfully, AI can act as an early warning system—augmenting leadership visibility and helping organizations act sooner, not just smarter.

**Accelerate the timeline from insight to action.** Even the most innovative technologies and comprehensive data will fall short without disciplined execution. Engage objective, external expertise to translate insight into action, strengthen governance discipline, redesign high-risk workflows, and build leadership capability at every level. Structured safety and reliability consulting can help turn safety from a priority into a daily operating reality.

**Measure and benchmark the health of your learning system—not just event volume.** Reporting frequency alone does not signal maturity. Responsiveness, feedback loops, cause analysis rigor, and action plan completion do. Comparative benchmarking through the High Reliability Platform provides visibility into how effectively organizations learn, respond, and improve over time.

**Engage in a broader community of learning.** Sharing data, trends, and lessons with peers expands visibility beyond internal events and accelerates progress toward zero harm. Participation in a Patient Safety Organization (PSO) expands learning beyond organizational boundaries, enabling health systems to identify emerging risks, benchmark performance, and apply collective insight to strengthen reliability.

**Embed experience data into safety oversight.** Patient perceptions of responsiveness and teamwork are early warning indicators of clinical reliability. When experience scores decline, harm rates often follow. Integrating patient experience, workforce, and safety event data into a unified governance view helps detect converging risk signals and reinforce coordinated improvement efforts.

**Close the after-hours gap.** Night-shift performance represents a distinct operational reality, not simply an extension of daytime care. Lower perceptions of safety culture, higher exposure to violence, and reduced leadership presence create structural vulnerabilities. Examine shift-level safety, workforce, and patient experience data in tandem to identify and address reliability gaps where risk is most likely to accumulate.

**When you make changes, make them visible.** Psychological safety improves when employees see their concerns lead to action. Monitor feedback, and articulate improvements made as a result. Closing the loop strengthens reporting culture and reinforces trust that leadership takes concerns seriously. HRP's AI tools help you do the follow-up and feedback.

## Accelerate the journey toward zero harm

Press Ganey helps operationalize and measure safety at scale. Reach out to an expert at:
pressganey.com/speak-to-an-expert

## About the data

Press Ganey's "**State of Healthcare Safety 2026**" report highlights employee perceptions of safety culture, patient perceptions of safety, nursing-sensitive indicators (NSI), and assault trends, as well as reported safety events. The safety culture data reflects the voices of 1.3M healthcare employees—including clinical professionals, nurses, advanced practice providers, physicians, clerical workers, licensed technical workers, security and maintenance professionals, midlevel management, nonclinical professionals, and senior management—from 225 health systems and 3,846 facilities. Patients' perception of safety is represented through the voices of nearly 23.5M patients from 3,196 sites across inpatient, ambulatory surgery, and medical practice experiences. NSI trend data represents 986 organizations and 386 sharing assaults data. Press Ganey PSO—the largest in the country—represents more than 190 health systems and 7.1M safety events. Learning system data within Press Ganey's High Reliability Platform includes 120 systems and more than 1M events.

## About the Press Ganey Signature Report Series

The Press Ganey Signature Report Series defines the annual conversation around Human Experience and performance across industries. Powered by one of the most expansive and integrated primary data ecosystems in the market, the series draws on millions of employee, consumer, member, and customer voices, alongside operational and outcomes data, to uncover the system-level forces shaping trust, loyalty, safety, and engagement. By connecting experience, culture, and performance at scale, Press Ganey provides a uniquely comprehensive view of the forces shaping outcomes across industries.

In healthcare, Press Ganey draws on one of the industry's most comprehensive and integrated data sets, spanning safety culture, workforce engagement, patient experience, clinical outcomes, and the nation's largest Patient Safety Organization.