Supplement

Table 1: Overall distribution of positive responses for 42 items included in the 12 patient safety culture dimensions of HSOPSC

Patient safety culture dimension	**Cumulative*** (%)	**2018 AHRQ Benchmarks** (%)
1. Overall perception of safety	**70 (>50th)**	**66**
a. It is just by chance that more serious mistakes do not happen around here (R)	44.6(<10th)	65
b. Patient safety is never sacrificed to get more work done	79.3 (>90th)	63
c. We have patient safety problems in this unit (R)	72.3 (>25th)	74
d. Our procedures and systems are good at preventing errors from happening	83.6 (>90th)	64
2. Supervisor/manager's expectations and actions promoting patient safety	**70 (<10th)**	**80**
a. My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures	80.9 (>50th)	79
b. My supervisor/manager seriously considers staff suggestions for improving patient safety	81.3 (>50th)	80
c. Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts (R)	69.7 (<10th)	79
d. My supervisor/manager overlooks patient safety problems that happen over and over (R)	48.2(<10th)	80
3. Organizational learning and continuous improvement	**85 (>90th)**	**72**
a. We are actively doing things to improve patient safety	90.7 (>50th)	84
b. Mistakes have led to positive changes here	78.9 (>90th)	63
c. After we make changes to improve patient safety, we evaluate their effectiveness	86.0 (>90th)	70
4. Teamwork within units	**83 (50th)**	**82**
a. People support one another in this unit	88.9 (>50th)	88
b. When a lot of work needs to be done quickly, we work together as a team to get the work done	85.7 (>25th)	87
c. In this unit, people treat each other with respect	82.9 (>25th)	82
d. When one area in this unit gets really busy, others help out	73.7 (>50th)	72
5. Nonpunitive response to error	**41 (25th)**	**47**
a. Staff feel like their mistakes are held against them (R)	45.5(>25th)	53
b. When an event is reported, it feels like the person is being written up, not the problem (R)	46.8 (>25th)	50
c. Staff worry that mistakes they make are kept in their personnel file (R)	29.7 (<10th)	39
6. Staffing	**40 (<10th)**	**50**
a. We have enough staff to handle the workload	61.1 (>75th)	52
b. Staff in this unit work longer hours than is best for patient care (R)	25.1 (<10th)	48
c. We work in "crisis mode" trying to do too much, too quickly (R)	34.9 (<10th)	50
7. Management support for patient safety	**73 (>50th)**	**72**
a. Hospital management provides a work climate that promotes patient safety	88.9 (>75th)	81

b. The actions of hospital management show that patient safety is a top priority	87.0 (>75th)	76
c. Hospital management seems interested in patient safety only after an adverse event happens (R)	42.9 (>25th)	59
8. Teamwork across hospital units	**76 (>90th)**	**62**
a. Hospital units do not coordinate well with each other (R)	70.3 (>75th)	63
b. There is good cooperation among hospital units that need to work together	79.5 (>90th)	49
c. It is often unpleasant to work with staff from other hospital units (R)	69.8 (>25th)	72
d. Hospital units work well together to provide the best care for patients	84.6 (>90th)	62
9. Hospital handoffs and transitions	**66 (>75th)**	**48**
a. Things "fall between the cracks" when transferring patients from one unit to another (R)	67.2 (>90th)	42
b. Important patient care information is often lost during shift changes (R)	69.3 (>90th)	53
c. Problems often occur in the exchange of information across hospital units (R)	62.4 (>75th)	47
d. Shift changes are problematic for patients in this hospital (R)	64.3 (>90th)	48
10. Communication openness	**72 (>75th)**	**66**
a. Staff will freely speak up if they see something that may negatively affect patient care	87.7 (>90th)	79
b. Staff feel free to question the decisions or actions of those with more authority	82.3 (>90th)	50
c. Staff are afraid to ask questions when something does not feel right (R)	46.0 (<10th)	68
11. Feedback and communications about error	**91 (>90th)**	**69**
a. We are given feedback about changes put into place based on event reports	88.6(>90th)	61
b. We are informed about errors that happen in this unit	91.8 (>90th)	69
c. In this unit, we discuss ways to prevent errors from happening again	91.3 (>90th)	76
12. Frequency of events reported	**71 (>50th)**	**67**
a. When a mistake is made, but is caught (noticed, discovered) and corrected before it affects the patient, how often is this reported?	74.0 (>90th)	62
b. When a mistake is made, but has no potential to harm the patient, how often is this reported?	67.9 (>50th)	63
c. When a mistake is made that could harm the patient, but does not, how often is this reported?	72.0 (>10th)	76

(R) - Negatively worded items that were reverse coded.

*% positives (Percentiles compared to AHRQ)

Table 2. Distribution of positive responses among healthcare providers at AKUH.

Patient safety culture dimension	Nurses and midwives ǂ (n=886)	Physicians (n=285)	Technologists (n=469)	Hospital Aide (n=658)	Management (n=250)	Others‡ (n=411)
			(%)			
1. Overall perception of safety	**66**	**69**	**73**	**71**	**73**	**71**
a. It is just by chance that more serious mistakes do not happen around here (R)	39.4	68.0	45.0	35.8	53.3	47.3
b. Patient safety is never sacrificed to get more work done	76.1	63.1	84.5	86.8	79.4	79.0
c. We have patient safety problems in this unit (R)	69.3	69.3	75	73.4	79.2	72.1
d. Our procedures and systems are good at preventing errors from happening	80.6	75.5	88.1	88.1	82.2	84.0
2. Supervisor/manager's expectations and actions promoting patient safety	**65**	**76**	**70**	**70**	**75**	**73**
a. My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures	76.1	75.2	82.1	86.9	82.9	83.1
b. My supervisor/manager seriously considers staff suggestions for improving patient safety	76.2	76.7	83.6	87.6	81.7	82.4
c. Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts (R)	70.7	74.9	68.9	65.8	72.0	69.7
d. My supervisor/manager overlooks patient safety problems that happen over and over (R)	36.3	78.1	47	40.8	65.2	56.6
3. Organizational learning and continuous improvement	**82**	**76**	**87**	**91**	**85**	**86**
a. We are actively doing things to improve patient safety	86.3	86.6	92.4	95.9	91.1	92.9
b. Mistakes have led to positive changes here	76.5	70.1	81.5	85.0	77.3	78.8
c. After we make changes to improve patient safety, we evaluate their effectiveness	84.0	72.7	87.5	92.6	87.9	86.4
4. Teamwork within units	**78**	**77**	**84**	**89**	**85**	**85**
a. People support one another in this unit	85.7	82.7	89.9	93.4	89.8	91.6
b. When a lot of work needs to be done quickly, we work together as a team to get the work done	79.2	82.8	86.6	92.3	88	88.5
c. In this unit, people treat each other with respect	75.9	77.1	85.3	90.9	84.2	86.2
d. When one area in this unit gets really busy, others help out	71.7	63.6	73.3	78.9	77.8	75.5

5. Non-punitive response to error	**39**	**42**	**41**	**39**	**46**	**41**
a. Staff feel like their mistakes are held against them (R)	43.4	51.5	45.5	44.6	48.4	45.4
b. When an event is reported, it feels like the person is being written up, not the problem (R)	45.6	42.0	48.6	43.9	54.7	50.8
c. Staff worry that mistakes they make are kept in their personnel file (R)	28.9	32.0	28.5	29.1	36.1	28.2
6. Staffing	**40**	**36**	**38**	**42**	**46**	**42**
a. We have enough staff to handle the workload	61.9	39.8	60.7	69.4	65.3	58.7
b. Staff in this unit work longer hours than is best for patient care (R)	28.5	34.4	16.4	19.1	31.1	27.6
d. We work in "crisis mode" trying to do too much, too quickly (R)	28.8	35.2	36.5	37.3	40.5	39.1
7. Management support for patient safety	**74**	**73**	**79**	**81**	**81**	**81**
a. Hospital management provides a work climate that promotes patient safety	85.7	82.7	89.9	93.4	89.8	91.6
b. The actions of hospital management show that patient safety is a top priority	84.2	76.1	90.5	92.5	88.0	87.8
c. Hospital management seems interested in patient safety only after an adverse event happens (R)	52.1	60.2	57.0	56.7	63.7	62.8
8. Teamwork across hospital units	**72**	**69**	**78**	**81**	**78**	**77**
a. Hospital units do not coordinate well with each other (R)	67.2	66.0	71.9	73.0	73.1	72.5
b. There is good cooperation among hospital units that need to work together	77.4	64.1	81.9	88.4	78.9	78.3
c. It is often unpleasant to work with staff from other hospital units (R)	63.0	74.4	71.4	71.2	76.7	73.0
d. Hospital units work well together to provide the best care for patients	81.5	70.7	88.5	92.9	84.2	84.3
9. Hospital handoffs and transitions	**62**	**60**	**66**	**70**	**67**	**71**
a. Things “fall between the cracks” when transferring patients from one unit to another (R)	63.5	58.8	69.3	69.4	71.1	73.3
b. Important patient care information is often lost during shift changes (R)	66.0	68.1	68.3	70.5	70.9	75.7
c. Problems often occur in the exchange of information across hospital units (R)	57.1	60.3	62.6	69.2	60.6	65.8
d. Shift changes are problematic for patients in this hospital (R)	62.5	54.1	62.3	69.6	64.2	69.3
10. Communication openness	**75**	**73**	**75**	**75**	**74**	**75**

a. Staff will freely speak up if they see something that may negatively affect patient care	85.6	89.3	89.0	86.3	88.7	91.1
b. Staff feel free to question the decisions or actions of those with more authority	83.5	77.9	79.6	85.8	84.2	78.8
c. Staff are afraid to ask questions when something does not feel right (R)	57.1	52.1	55.1	52.0	48.6	53.6
11. Feedback and communications about error	**88**	**88**	**91**	**92**	**93**	**92**
a. We are given feedback about changes put into place based on event reports	85.7	85.5	89.8	90.6	90.7	91.3
b. We are informed about errors that happen in this unit	90.9	89.7	91.5	93.4	93.1	92.3
c. In this unit, we discuss ways to prevent errors from happening again	88.9	90.3	92.7	91.6	94.7	92.8
12. Frequency of events reported	**73**	**70**	**70**	**69**	**72**	**72**
a. When a mistake is made, but is caught (noticed, discovered) and corrected before it affects the patient, how often is this reported?	75.4	69.3	73.7	71.8	75.8	77.1
b. When a mistake is made, but has no potential to harm the patient, how often is this reported?	75.7	61.4	65.7	68.3	63.5	65.7
c. When a mistake is made that could harm the patient, but does not, how often is this reported?	72.8	75.4	71.7	67.0	76.9	73.0