Table 1 – Factors Analysis Models

(Items shown in **red text** are the 19 retained items that are recommended for the final measurement model of patient safety climate).

Item#[¥]	Item	Measurement models tested				
		EFA	CFA-1	CFA-2 CFA-3[†]	CFA-4 CFA-5[†]	CFA-6
Organizational (senior) leadership support for safety						
OL_1	Senior management has a clear picture of the risk associated with patient care	F1	F1	F1	F1	F1
OL_4	Patient safety decisions are made at the proper level by the most qualified people	F1	F1	F1	F1	F1
OL_5	Senior management provides a climate that promotes patient safety	F1	F1	F1	F1	F1
OL_9	Senior management considers patient safety when program changes are discussed	F1	F1	F1	F1	F1
OL_22	My organization effectively balances the need for patient safety and the need for productivity	F1	F1	F1	*	n/a
OL_2	Good communication flow exists up the chain of command regarding patient safety issues	F1	F1	*	n/a	n/a
OL_23	I work in an environment where patient safety is a high priority	F1	F1	*	n/a	n/a
Incident follow up						
@17	If I report a patient safety incident, someone usually follows up to get more information from me	F1	F7	F7	F6	F6
@20	If I point out a potentially serious patient safety incident, management will look into it	F1	F7	F7	F6	F6
@24	Staff are usually given feedback about changes put into place based on incident reports	F1	F7	F7	F6	F6
@8	There is no point in talking about a patient safety problem because nothing usually gets done about it	F1	F7	*	n/a	n/a
Supervisory leadership for safety						
SL_29	My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures	F5	F5	F5	F5	F5
SL_30	My supervisor/manager seriously considers staff suggestions for improving patient safety	F5	F5	F5	F5	F5
@27	If I made a serious error my manager would be supportive	F5	F5	*	n/a	n/a
SL_31	Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts	F6	F6	F6	*	n/a
SL_32	My supervisor/manager overlooks patient safety problems that happen over and over	F6	F6	F6	*	n/a
LC_37	On this unit, it is difficult to discuss errors	F6	F6	F6	*	n/a
@15	On this unit it is difficult to speak up if you feel there is a problem related to patient safety	F6	F6	*	n/a	n/a
@19	On this unit it is difficult to question the decisions or actions of those with more authority	F6	F6	*	n/a	n/a
Unit learning culture						
LC_33	On this unit, when a serious error occurs, we think about it carefully	F2	F2	F2	F2	F2
LC_35	On this unit, after a serious error has occurred, we think about how it came about and how to prevent the same mistake in the future	F2	F2	F2	F2	F2
LC_36	On this unit, when a serious error occurs, we analyze it thoroughly	F2	F2	F2	F2	F2
LC_38	On this unit, after a serious error has occurred, we think long and hard about how to correct it	F2	F2	F2	F2	F2
LC_34	On this unit, when people make a serious error, they ask others about how they could have prevented it	F2	F2	*	n/a	n/a

Item#[¥]	Item	Measurement models tested				
		EFA	CFA-1	CFA-2 CFA-3[†]	CFA-4 CFA-5[†]	CFA-6
Enabling Open Communication I: judgment-free environment						
@11rev	If I make a serious error my manager will think I am incompetent	F3	F3	F3	F3	F3
@16rev	My co-workers will lose respect for me if they know I've made a serious error	F3	F3	F3	F3	F3
@21rev	Others make you feel like a bit of a failure when you make an error	F3	F3	F3	F3	F3
@7	I would feel ashamed if I made a serious error and my co-workers heard about it	F3	F3	*	n/a	n/a
@10	My co-workers will think I am incompetent if they know I've made a serious error	F3	F3	*	n/a	n/a
Enabling Open Communication II: job repercussions of error error						
@18rev	Making a serious error may cause a staff member to lose his/her job.	F4	F4	F4	F4	F4
@25rev	If I make a serious error I worry that I will face disciplinary action from management	F4	F4	F4	F4	F4
@26rev	Making a serious error would limit my career opportunities around here	F4	F4	F4	F4	F4
@3	If I make a serious error I worry that I will face disciplinary action from the college	F4	F4	*	n/a	n/a
SL_13	I am rewarded for taking quick action to identify a serious error	C/LL	*	n/a	n/a	n/a
@6	When an incident is reported, it seems like the person is being written up, not the problem	C/LL	*	n/a	n/a	n/a
@12	On my unit, staff who report a *co-worker's* error are labelled as 'not being a team player	C/LL	*	n/a	n/a	n/a
@14	My co-workers would support me if they learned of a serious error I made	C/LL	*	n/a	n/a	n/a
@28	Individuals involved in patient safety incidents have a quick and easy way to report what happened	n/a	n/a	n/a	n/a	n/a

[¥] Number notation indicates item dimension in the MSI 2010: item #s preceded by the @ sign were new in the MSI 2010, OL = Organizational leadership for safety, SL = supervisory leadership for safety, LC = unit learning culture

* Item not well accounted for by previous model and was removed in the current model

n/a not included in the model

† Multiple-group CFA

C/LL Cross loading or low loading