Definitions of "errors" and "harm" in the survey questions are as follow:

- **Errors**: The failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim.
- **Harm**: Unintended harm to the patient by an act of commission or omission rather than by the underlying disease or condition of the patient.

Ⅰ. Please indicate your opinion on how much you agree with each of the following questions:

1	2	3	4	5
Strongly disagree	Disagree	Neither disagree nor agree	Agree	Strongly agree

1.	Making errors in healthcare is preventable.	1	2	3	4	5
2.	Healthcare professionals should make an effort to improve patient safety.	1	2	3	4	5
3.	Healthcare professionals should not tolerate uncertainty in patient care.	1	2	3	4	5
4.	Learning how to improve patient safety is an appropriate use of time in health programs in school.	1	2	3	4	5
5.	Healthcare professionals routinely share information about medical errors and what caused them.	1	2	3	4	5
6.	Patient safety is a high priority to healthcare professionals.	1	2	3	4	5
7.	Healthcare professionals should routinely report whenever certain errors occur.	1	2	3	4	5
8.	Healthcare professionals should disclose errors to an affected patient and his or her family.	1	2	3	4	5
9.	If there is no harm to the patient, there is no need to report an error.	1	2	3	4	5
10.	If I saw an error, I would keep it to myself.	1	2	3	4	5
11.	Technology and information management tools (e.g., bar codes, electronic medical record, automatic alerts and alarms) should be used appropriately to support safe processes of care.	1	2	3	4	5
12.	Value own role in preventing errors.	1	2	3	4	5
13.	Value nurses' involvement in design, selection, implementation, and evaluation of information technologies to support patient care.	1	2	3	4	5
14.	A standardized procedure minimizes risks associated with handoff(e.g., transfer, shifts) within disciplines and across transitions in care.	1	2	3	4	5

Ⅱ. Please indicate your opinion on <u>how skillful you are at</u> performing each of the following tasks:

1	2	3	4	5
I am barely capable of performing the tasks	I have difficulty performing the tasks	I am capable of performing the tasks	I am capable of performing the tasks skillfully	I am capable of performing the tasks very skillfully

1.	Report errors using an organizational error reporting system.	1	2	3	4	5
2.	Accurately enter an error report.	1	2	3	4	5
3.	Analyze a case to find the causes of an error.	1	2	3	4	5
4.	Support and advise a peer who must decide how to respond to an error.	1	2	3	4	5
5.	Disclose an error to a faculty member.	1	2	3	4	5
6.	Communicate observations or concerns related to hazards or errors with health care professionals.	1	2	3	4	5
7.	Communicate observations or concerns related to hazards or errors with an affected patients and his or her family.	1	2	3	4	5
8.	Locate evidence reports related to clinical practice topics and guidelines to define uncertainty in nursing care.	1	2	3	4	5
9.	Use high quality electronic sources of health care information (e.g., online medical database).	1	2	3	4	5
10.	Use technology and information management tools (e.g., barcodes, electronic medical record, and automatic alerts and alarms) to support safe processes of care.	1	2	3	4	5
11.	Prevent and manage pressure ulcers.	1	2	3	4	5
12.	Practice hand hygiene to prevent infection.	1	2	3	4	5
13.	Use falls risk assessment tool to prevent falls.	1	2	3	4	5
14.	Give a blood transfusion according to transfusion policies for safe care.	1	2	3	4	5
15.	Administer drug to patient according to medication policies for safe care.	1	2	3	4	5
16.	Follow communication practices that minimize risks associated with hand offs between and among providers and across transitions in care.	1	2	3	4	5
17.	Document hand-off communication according to institutional policies.	1	2	3	4	5
18.	Use standard infection control precautions for all patient encounters and other transmission precautions as appropriate.	1	2	3	4	5
19.	Use appropriate personal protective equipment (e.g., mask, goggles, gloves).	1	2	3	4	5
20.	Apply aseptic technique when inserting invasive devices as appropriate for patient care procedures (e.g., foley catheter insertion, intravenous catheter insertion, dressing).	1	2	3	4	5
21.	Check patient's identity accurately (e.g., a registration number, birth date, name).	1	2	3	4	5

Ⅲ. Please indicate your opinion on <u>how much you are aware of</u> each of the following items:

1	2	3	4	5
I am hardly aware	I am not well aware	I am aware	I am well aware	I am very aware

1.	Describe factors that create a culture of safety (e.g., teamwork, leadership, effective communication).	1	2	3	4	5
2.	Describe role of human factors in assuring safety. (e.g., physical, psychological limitations of human, interactions between human and instrument)	1	2	3	4	5
3.	Distinguish among errors, adverse events, near misses, and hazards.	1	2	3	4	5
4.	Describe processes used in analyzing causes of error (e.g., root cause analysis).	1	2	3	4	5
5.	Describe the impact (benefits and limitations) of technology and information management care (e.g., bar codes, electronic medical record, medication pumps, and automatic alerts and alarms).	1	2	3	4	5
6.	Explain how authority gradients (horizontal, vertical) influence teamwork and patient safety.	1	2	3	4	5