Appendix 1: Percentage responses to HSOPC items

Question Number	Item					
		Strongly Disagree	**Disagree**	**Neither Disagree or Agree**	**Agree**	**Strongly Agree**
A25	Patient safety is never sacrificed to get the work done	4.5	19.6	16.8	45.8	13.3
A30	Our procedures and systems are good at preventing errors from happening	2.0	9.9	21.7	59.0	7.4
A18	It is just by chance that serious mistakes don't happen around here	13.3	40.3	19.0	22.1	5.3
A28	We have patient safety problems in this ward/department	11.5	45.6	22.8	17.2	2.8
		Never	**Rarely**	**Sometimes**	**Most of the time**	**Always**
D1	When an event occurs, but is caught and identified before affecting the patient, how often is it reported?	1.4	10.0	23.8	41.6	23.3
D2	When an event occurs, but it has no adverse outcome to the patient, how often is it reported?	0.9	8.4	20.6	43.5	26.7
D3	When an event occurs that could have an adverse outcome to the patient but does not, how often is it reported?	0.4	5.5	16.0	39.4	38.7
		Strongly Disagree	**Disagree**	**Neither Disagree or Agree**	**Agree**	**Strongly Agree**
B1	My supervisor/manager provides positive feedback when he/she sees a job done according to established patient safety procedures	5.5	18.4	19.9	45.9	10.4
B2	My supervisor/manager seriously considers staff suggestions for improving patient safety	3.0	7.4	16.2	60.4	13.1
B3	Whenever pressure build up, my supervisor/manager wants us to work faster, even if it means taking shortcuts	14.9	53.9	17.4	11.3	2.6

Appendix 1: Percentage responses to HSOPC items

Question Number	Item	Never	Rarely	Sometimes	Most of the time	Always
B4	My supervisor/manager overlooks patient safety problems that happen repeatedly	26.7	47.2	12.2	10.6	3.4
A14	We are actively doing things to improve patient safety	0.8	4.6	17.8	63.1	13.6
A16	Mistakes have led to positive changes around here	1.9	8.1	24.9	59.2	5.9
A22	After we make changes to patient safety, we evaluate their effectiveness	1.4	12.6	28.6	52.5	4.9
A1	People support one another in this ward/department	1.0	6.4	7.4	60.8	24.4
A3	When a lot of work needs to be done quickly, we work together as a team to get the work done	1.4	6.1	8.0	63.9	20.6
A7	In this ward/department, people treat each other with respect	2.1	10.2	11.1	60.9	15.7
A20	When one area in this ward/department gets busy, others help out	7.1	23.1	15.0	45.9	8.0
C3	Staff will freely speak up if they see something that may negatively affect patient care	0.8	4.6	21.3	49.1	24.2
C8	Staff feel free to question the decisions and actions of those with more authority	3.7	16.2	34.3	34.3	11.5
C11	Staff are afraid to ask questions where something doesn't seem right	2.2	8.4	30.0	42.8	16.7
C1	We are given feedback about changes put into place based on event reports	3.3	15.3	33.2	36.1	12.2
C7	We are informed about events that happen in this ward/department	2.2	10.9	27.9	42.6	16.5
C9	In this ward/department, we discuss ways to prevent events from happening again	2.1	9.1	28.3	41.5	19.0
A15	Staff feel that their mistakes are held against them	4.7	20.4	24.5	43.6	6.9

Appendix 1: Percentage responses to HSOPC items

Question Number	Item	Never	Rarely	Sometimes	Most of the time	Always
A26	Staff worry that mistakes they make are kept in their personal files	5.6	31.1	31.0	28.1	4.2
A2	We have enough staff to handle the workload	16.5	38.1	13.7	28.4	3.3
A12	Staff in this ward/department work longer hours that is best for patient care	8.5	24.6	28.9	33.8	4.1
A13	We use more agency/temporary staff than is best for patient care	2.7	11.6	18.9	40.1	26.7
A24	We often work in “crisis mode” trying to do too much, too quickly	13.1	39.9	19.7	24.1	3.2
F10	The actions of hospital management show that patient safety is a top priority	4.8	19.0	31.0	37.4	7.7
F11	Hospital management seems interested in patient safety only after an adverse event happens	8.1	36.0	23.6	27.8	4.6
F4	There is good cooperation across hospital wards/departments that need to work together	3.4	24.7	30.2	38.5	3.1
F13	Hospital wards/departments work well together to provide the best care for patients	1.8	15.5	30.9	45.2	6.5
F2	Hospital wards/departments do not coordinate well with each other	14.4	41.7	22.1	19.5	2.3
F7	It is often unpleasant to work with staff from other hospital wards/departments	2.2	12.2	30.5	46.8	8.3
F3	Things “fall between the cracks” when transferring patients from one ward/department to another	15.6	42.7	23.6	16.4	1.6
F5	Important patient care information is often lost during shift changes	6.3	27.8	25.8	34.6	5.5
F9	Problems often occur in the exchange of information across hospital wards/departments	7.3	46.5	25.4	19.4	1.4

Appendix 1: Percentage responses to HSOPC items

Question Number	Item	Never	Rarely	Sometimes	Most of the time	Always
F14	Shift changes are problematic for patients in this hospital	3.9	23.5	35.5	31.8	5.4

Appendix 2: Revised 9-dimensional model fitted to the UK data: EFA, CFA and reliability analyses

	Dimension/ Item	Factor Loadings from EFA	Standardised Path Coeffiecient	Item R^2 from CFA	Reliability of Dimensions
Frequency of error reporting					0.83
D1	When an event occurs, but is caught and identified before affecting the patient, how often is it reported?	0.73	0.71	0.51	
D2	When an event occurs, but it has no adverse outcome to the patient, how often is it reported?	0.93	0.92	0.85	
D3	When an event occurs that could have an adverse outcome to the patient but does not, how often is it reported?	0.87	0.75	0.56	
Staffing and overall perceptions of safety					0.70
A2	We have enough staff to handle the workload	0.77	0.46	0.21	
A24	We often work in “crisis mode” trying to do too much, too quickly	0.79	0.56	0.32	
A18	It is just by chance that serious mistakes don’t happen around here	0.60	0.67	0.45	
A28	We have patient safety problems in this ward/department	0.66	0.58	0.33	
Supervisor/manager expectations and actions promoting patient safety					0.76
B1	My supervisor/manager provides positive feedback when he/she sees a job done according to established patient safety procedures	0.85	0.76	0.57	
B2	My supervisor/manager seriously considers staff suggestions for improving patient safety	0.77	0.81	0.65	
Teamwork within units					0.78
A1	People support one another in this ward/department	0.78	0.80	0.64	
A3	When a lot of work needs to be done quickly, we work	0.80	0.69	0.47	

Appendix 2: Revised 9-dimensional model fitted to the UK data: EFA, CFA and reliability analyses

	Dimension/ Item	Factor Loadings from EFA	Standardised Path Coeffiecient	Item R^2 from CFA	Reliability of Dimensions
	together as a team to get the work done				
A7	In this ward/department, people treat each other with respect	0.80	0.82	0.66	
Non-punitive response to error					0.65
A15	Staff feel that their mistakes are held against them	0.70	0.88	0.78	
A26	Staff worry that mistakes they make are kept in their personal files	0.88	0.58	0.34	
Communication openness					0.67
C3	Staff will freely speak up if they see something that may negatively affect patient care	0.62	0.70	0.49	
C8	Staff feel free to question the decisions and actions of those with more authority	0.48	0.74	0.55	
C11	Staff are afraid to ask questions where something doesn't seem right	0.84	0.49	0.24	
Feedback and communication about error					0.80
C1	We are given feedback about changes put into place based on event reports	0.78	0.73	0.53	
C7	We are informed about events that happen in this ward/department	0.81	0.75	0.56	
C9	In this ward/department, we discuss ways to prevent events from happening again	0.68	0.77	0.60	
Teamwork across hospital units					0.73
A1	People support one another in this ward/department	0.76	0.70	0.49	
A3	When a lot of work needs to be done quickly, we work	0.76	0.66	0.44	

Appendix 2: Revised 9-dimensional model fitted to the UK data: EFA, CFA and reliability analyses

	Dimension/ Item	Factor Loadings from EFA	Standardised Path Coeffiecient	Item R^2 from CFA	Reliability of Dimensions
	together as a team to get the work done				
A7	In this ward/department, people treat each other with respect	0.68	0.69	0.48	
Hospital handovers and transitions					0.77
F3	Things “fall between the cracks” when transferring patients from one ward/department to another	0.61	0.71	0.51	
F5	Important patient care information is often lost during shift changes	0.81	0.70	0.48	
F9	Problems often occur in the exchange of information across hospital wards/departments	0.75	0.74	0.55	
F14	Shift changes are problematic for patients in this hospital	0.72	0.56	0.31	