

**The Hospital Survey on Patient Safety Culture in Mexican Hospitals: Assessment of
Psychometric Properties**

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ABSTRACT

This study investigates the psychometric properties of the Hospital Survey on Patient Safety Culture (HSPSC) in a Mexican sample of hospitals. The data were collected from 788 clinical staff from 6 hospitals. An exploratory factor analysis was conducted on the data set, and confirmatory factor analysis was conducted on the validation data set to explore and check the original US model fit in a Mexican sample. Additionally, we tested the relationship between the HSPSC dimensions and the perceived healthcare service quality (source = patients) as well as employees engagement. Our results showed a 9-factor optimal measurement model. The confirmatory factor analyses were then performed to compare the model fit of three competing models (9-factor alternative model vs 12-factor original model vs the single factor model). The original 12-factor model performed significantly worse in a Mexican sample. Furthermore, the 9-factor solution yielded the most satisfactory levels of reliability for each component. The mean scores of the patient safety culture dimensions in the Mexican sample were comparable with those found in previous studies conducted in different countries. However, this is the first systematic analysis of the psychometric properties of the Spanish version of the HSPSC conducted in a Latino American country. This study provided evidence that the original 12-factor structure of the HSPSC has not been replicated in a Mexican sample of hospitals.

Highlights:

- Nine-factor solution of the Spanish version of the HSPSC
- Predictive validity of patients' service quality perception
- Predictive validity of employees' engagement

Keywords: Healthcare, Safety Culture and Climate, Hospital Survey on Patient Safety Culture, Mexican version, Psychometric Properties.

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1) INTRODUCTION

Recent research has revealed that medical errors are among the top three causes of death in the USA (Makary & Daniel, 2016). Unsafe healthcare treatments and practices may be at the core of incidents in hospital settings such as patients' injuries, falls, infections and longer hospital stays (Hofmann & Mark, 2000). Under these circumstances, a strong patient safety culture has been demonstrated to be related with patient safety and service quality outcomes (e.g., Naveh, Katz-Navon & Stern, 2005; Vogus & Sutcliffe, 2007; Sorra et al., 2012). Several safety-climate instruments have been developed within healthcare industry, and have been also translated and adapted for application in different countries (e.g., Gershon et al., 2000; Neal et al., 2000; Sexton et al., 2006; Vogus & Sutcliffe, 2007). Among these instruments, the Hospital Survey on Patient Safety Culture (HSPSC) has been widely utilized in the last decade by both researchers and practitioners in the healthcare sector worldwide.

The HSPSC was originally developed and released by the American Agency for Healthcare Research and Quality in 2004. This survey measures staff perceptions of patient safety climate in their work unit, as well as in the hospital as a whole. It is comprised of 42 items that group into 12 dimensions; two outcome dimensions and ten safety dimensions. For each item, there were five possible response categories (agree/disagree or never/always), the labelling of which varies across dimensions. Of the 42 items, 17 are asked from a "negative" viewpoint and are subsequently reverse-scored. The confirmatory factor analysis carried out during the development of the questionnaire indicated that the 12-factor model proposed had an adequate level of fit to the data using established criteria (Sorra & Nieva, 2006). However, studies conducted in different countries (both European and Non-European) have reported conflicting results of underlying factor structures. For example, while the 12-factor original solution was replicated in Belgian, Portuguese and Scottish samples (Hellings et al., 2007; Eiras et al., 2014; Sarac et al., 2011), German data revealed an 8-factor structure (Pfeiffer & Manser, 2010), French data resulted in 10 factors (Occelli et al., 2013), Dutch data resulted in 11 factors (Smits et al., 2008), English data resulted in 9 factors (Waterson et al.,

2010), and Chinese data resulted in 8 factors (Nie et al., 2013). These inconsistent results are not surprising considering the important differences in the samples (e.g., clinical vs non-clinical staff), the analytical techniques used (exploratory factor analysis vs confirmatory factor analysis), the heterogeneous cultural backgrounds, and the translations and modifications made to adapt the survey to the healthcare settings across the countries examined.

On the American Agency for Healthcare Research and Quality website, it has been informed that the Spanish version of the HSPSC instrument (translated in 2009 for Spanish-speaker US health-care workers) has been applied in five Latin American countries, including Peru, Chile, Colombia, El Salvador and Mexico (Brazil is not mentioned because Portuguese is the official language). However, we have not found any specific reference to a scientific paper, report or publication which systematically evaluates the psychometric properties of the Spanish version of the HSPSC questionnaire in Latin American countries. The national health system in Mexico has important differences with other countries both within and outside Latin America, such as different organization structures, policies, control and administrative systems, staffing and personnel policies, responsible units for quality and patient safety, and so on. For this reason, the main objective of this paper is to investigate the psychometric properties of the HSPSC in a Mexican sample of hospitals, with the purpose of providing a suitable questionnaire to assess the level of patient safety climate in hospitals and also to benchmark the data against other countries. A well-structured instrument would allow examination of the underlying causal mechanisms influencing patient safety-related outcomes in Mexican health-care settings, and it may be contrasted and extended to other Latin American countries. In this sense, our study contributes to extend evidence on the predictive validity of the HSPSC by analyzing the relationships between the instrument and other patient safety-related variables such as the patients' perceived healthcare service quality and employees' work engagement. From a conceptual perspective, these variables are expected to be positively related with a hospital's strong patient safety culture as assessed by the HSPSC. From a psychometric

perspective, performing this type of validity tests is especially relevant for providing additional evidence on the validity of the survey based on the empirical association with theoretically related constructs (DeVellis, 1991).

2) MATERIAL AND METHODS

2.1) Sample and Measures

The HSPSC paper-based questionnaire (adapted Spanish version) was distributed to clinical staff of six public hospitals in Mexico (see Appendix 1). The total population of employees in the six hospitals was 3975 individuals. In cooperation with the managers of the different HR departments, we identified a sample of 1300 potential participants (distributed across the different hospitals and units) based on the availability of the employees, but also ensuring the heterogeneity of the different healthcare services. Of the 1300 potential participants, a final sample of 950 employees agreed to participate in the study. The questionnaires were provided to all them, and 866 were returned. 788 participants provided valid responses to all survey items. Thus, the response rate (distributed questionnaires/valid questionnaires) was 60.61%, which represents the 19.82% of the whole population of employees. Within the final sample, 63.38% of the participants were female and 36.62% were male. The mean age was 35.38 years old ($SD = 10.89$), and the average profession tenure and organizational tenure were 12 years ($SD = 10.5$) and 9 years ($SD = 9.1$), respectively. Most of the participants were members of the nursing staff of the hospitals. They showed the best willingness to participate in the research, while medical staff showed less willingness to participate. Thus, the final sample was comprised as follows: nurses 47.6%, specialized doctors 26.8%, general doctors 4.3%, and personnel from social work, nutrition and psychology 21.3%.

Employees' engagement was assessed with the 9-item version of the Utrecht Work Engagement Scale (UWES; Schaufeli, Bakker & Salanova, 2006), made up of vigor (3-item subscale; e.g., "At my work, I feel bursting with energy"), dedication (3-item subscale; e.g., "My job

inspires me”), and absorption (3-item subscale; e.g., “I get carried away when I am working”). All items were scored on a 5-point frequency rating scale ranging from 1 (*never*) to 5 (*always*).

In addition, 1700 patients distributed across the six hospitals responded to the 22-item version of the SERVQUAL scale (Service Quality; Solves, Buil, Rodriguez-Marin & Aranaz, 1997). This scale rates the users’ perceptions and expectations of healthcare service quality. We fixed a priori a total number of 1700 patients according to the hospital size: 500 patients for the big hospitals, and 100 patients for the smaller ones. The data collection finished only when the fixed number was reached; the response rate was 30% of the approached patients. The final sample comprised users of different hospital services: emergency (49%), outpatient (25%), gynecology (15%), and pediatrics (11%). 74.5% of the users were women. The average age was 39 years old.

2.2) Procedure

The data collection was conducted from September 2015 to January 2016. The six hospitals were selected using a convenience sample which involved the employees’ willingness and consent to participate in the study. Clinical staff responded the questionnaire anonymously and voluntarily. The questionnaires were distributed in the hospitals with a consent form, which briefly explained the project. The researchers used the daily staff meetings and weekly training meetings to personally inform about the study across the different hospital units. The units’ managers were in charge of providing the questionnaires to the clinical staff willing to participate. After completion, both the questionnaires and consent forms were returned in separate sealed and unmarked envelopes, which were placed by each respondent in a specific box located in the nurses’ room of each hospital unit. The manager of each hospital unit collected all the envelopes and returned them to the research team. The research project was reviewed and approved by the research committee of each hospital.

For collecting the patients’ data, a specialized poll company was hired. The SERVQUAL survey forms were distributed among the patients in the waiting rooms of the outpatient medical

facilities during morning and evening shifts. The patients responded the surveys voluntarily and in privacy after their visit to the hospital services.

2.3) Adjustments to the HSPSC

Based on pre-survey group discussions with clinical staff members, we made a number of changes on the Spanish version of the HSPSC. These included adjustments to the wording of individual items regarding both the technical terminology and vocabulary normally used within Mexico. Appendix 1 shows the translated and adapted Spanish version of the HSPSC used in our study.

2.4) Data Analysis

Psychometric analyses of the HSPSC included: (a) an exploratory factorial analysis (EFA) to test the theoretical structure of the survey, (b) a confirmatory factor analysis (CFA) to test the robustness of the nine versus single-factor solution, (c) reliability estimation, and (d) analysis of the relation between the HSPSC and other variables to offer evidence on the instrument's validity predicting: overall patient safety, frequency of reported events, patients' evaluation of service quality, and employees' work engagement.

Reliability for each scale score was estimated using Cronbach's alpha coefficient. We computed missing data following recent recommendations suggesting the use of maximum likelihood-based estimation (Enders, 2010) because it produces less bias. Then, we proceed with the EFA to explore the underlying factors structure. To ensure that the data were appropriate to perform factor analysis, Kaiser's measure of sampling adequacy was firstly computed. Secondly, we calculated the Polychoric correlation matrix and chose Unweighted Least Square extraction method (Finney & DiStefano, 2006). To decide the number of factors to be retained, we run a parallel analysis (Hayton, Allen & Scarpello, 2004) and assessed the fit indexes and the interpretability of the rotated (using a Promin oblique Rotation) solution. Then, we performed the CFA on the second

randomly split sample using MLM on polychoric matrix (Finney & DiStefano, 2006). Both EFA and CFA were conducted with the software Mplus Criteria to evaluate the fit of the models including: a) the comparative fit index (CFI); b) the Tucker–Lewis Index (TLI); and c) the root mean square error of approximation (RMSEA) and the standardized SRMR. The following criteria were used to evaluate the goodness of fit: TLI and CFI should be close to or greater than 0.90 (Hu & Bentler, 1998), and RMSEA value should be 0.08 or lower (Browne & Cudeck, 1992). We also report (as descriptive data) the ratio of maximum-likelihood chi-square to the degrees of freedom (χ^2/df), but we did not take it into account to assess our model’s fit because using categorical data and small/medium samples it becomes inflated (DiStefano, 2009). Finally, we used bivariate correlations to study the relationships with other variables (DeVellis, 1991).

3) RESULTS

3.1) Exploratory Factorial Analysis

Based on the EFA results, we retained 9 factors instead of 12 factors as in the original version of the HSPSC. As shown in Table 1, our first factor accounted for the items representing the theoretical dimension of “teamwork within units” (corresponding to the fourth dimension in the original version); the second factor included the items of the dimension “supervisor expectation and action promoting safety” (second original dimension); the third factor included the items corresponding “organizational learning” and “overall perception of patient safety” (the tenth and eleventh original dimensions, respectively); the fifth factor included items from the “feedback and communication about errors” and “communication openness” (the fifth and eighth original dimensions, respectively); the sixth factor accounted for the items corresponding to “frequency of events reported” (twelfth original dimension); the seventh dimension included items from the “staffing” dimension (ninth original dimension); the eighth dimension included items from the “no punitive response to error” (seventh original dimension); our ninth dimension accounted for the items corresponding to the “teamwork across units” and “hands off and transitions” (the third and

sixth original dimensions, respectively).

--- Insert Table 1 about here ---

3.2) Confirmatory Factorial Analysis

Based on the CFA we compared our 9-factor model with the original 12-factor model as well as with a single-factor model. The 9-factor model presented the best fit to the data (TLI = 0.91, CFI = 0.89, RMSEA = 0.062, SRMR = 0.054, $\chi^2/df = 6.864$), followed by the 12-factor correlated model (TLI = 0.87, CFI = 0.84, RMSEA = 0.092, SRMR = 0.088, $\chi^2/df = 7.317$), while the single-factor model presented unacceptable fit.

3.3) Reliability and Predictive Validity Evidence

With respect to reliability, the overall instrument present an acceptable reliability ($\alpha = .71$); five of the extracted dimensions presented acceptable levels of reliability based on Cronbach's Alpha, ranging from .62 to .86 (see table 1). Regarding the study of the relation between the HSPSC and other variables, as shown in Table 2, all the 9 dimensions were related to patient safety, being dimension 1 the stronger predictor (ranging from $r = .096, p < .05$ to $r = .428, p < .01$). Considering the number of reported events, the stronger predictor was dimension 9 ($r = .170, p < .05$).

--- Insert Table 2 about here ---

Additionally, we tested the relationship between HSPSC and perceived healthcare service quality for 64 hospital units. Data were measured at the individual level (employees answered the HPSC questionnaire and patients answered the service quality scale). We aggregated members' responses to the unit level following multilevel procedures (Bliese, 2000). We found that in those units where the employees rated a stronger patient safety culture, the patients also reported higher levels of service quality ($r = .23, p < .01$). Similarly, in hospital units with a stronger patient safety culture, the employees reported higher mean levels of work engagement ($r = .40, p < .01$).

4) DISCUSSION

Our main goal with this paper was to develop and validate a Mexican version of the HSPSC to

be used in healthcare settings. As an overview of our results, the EFA shows that the nine-factor solution represents a highly significant proportion of the total variance and the items are easily assigned to their corresponding theoretical factors. Moreover, the CFA shows coherently that the nine-factor model displays the best fit, as compared to both the twelve and single-factor solutions. Our fit indexes reach the recommended levels for a good model fit. In addition, we have obtained good RMSEA and SRMR values, and TLI and CFI are close to the .90 recommended limit. Regarding internal consistency, the reliability of the nine-factor solution exceeds the accepted level using the Cronbach's Alpha, although some dimensions presented poor reliabilities (when computing the reliability on the single dimensions). On the one hand, this results is in line with previous survey's validations in the field, where the single dimensions reliability was shown to be weak (Waterson et al., 2010), indicating that the patient safety culture is a complex construct to be measured. On the other hand, the low reliability on the single dimensions can depend on the low number of items that is included in the estimation of the single dimensions, as Cronbach's Alpha is sensitive to the number of items (Sijtsma, 2009). Despite this limitation, most of the applied metric tests demonstrate good results.

Additionally, our study contributes to provide initial evidence on the predictive validity of the HPSC survey within Mexico. In particular, the results show a significant positive relation between the hospital units' safety culture and the quality of the delivered service assessed by the patients ($r = .23, p < .01$). Also, we found a significant positive relation between the hospital units' safety culture and the employees' work engagement ($r = .40, p < .01$). To the best of our knowledge, this is the first research published showing positive correlations of patient safety culture with key hospital's outcomes, such as service quality and employees' job attitudes, within healthcare organizations in Mexico. This is relevant not only because the predictive validity of the survey instrument is tested, but also because the results suggest that developing a strong patient safety culture may improve both perceived service quality and job engagement, which are two of the central enablers of high-

performing hospitals (Taylor et al., 2015). The assessment and measuring of safety culture and climate in healthcare is still less developed as compared to other industries (manufacturing, construction, offshore, etc.), although it is growing fast in recent years. Scholars have warned about the dangers of too readily generalizing about safety culture and climate across industries with significant differences in central factors (Amalberti & Vincent, 2016), such as organizational forms, work practices, staffing policies and rules. This is the case in healthcare which differs from almost all other safety-critical industries. For instance, what we regard as harm in civil aviation remains the same whatever advances may occur in aviation technology or practice, while the definition of harm in healthcare have evolved over time as safety is a constantly moving target (Vincent & Amalberti, 2015)

Our results support the argument that there is a need to further develop conceptual models that are sensitive to: 1) the context-specific nature of healthcare, including hospitals, clinics, nursing homes or mental health facilities, which may present important differences among them in terms of work structures, policies, resources, legal restrictions, etc., and 2) the cultural-specific characteristics of each country, given the significant variations observed in the healthcare systems of different countries worldwide, which help us to understand why the psychometric structure of the HPSC survey can vary even across countries with multiple similarities, such as Germany, France and The Netherlands. As scholars, we are at risk of adopting a broad-brush approach to safety culture and overgeneralizing the findings across industries and countries, if we omit those specific contextual and cultural-sensitive approaches to the development and management of patient safety culture.

Regarding the cross-cultural validation of the HSPSC, extant research shows heterogeneous dimensionality solutions across different European, Latino-American and North American countries. In this respect, our results are consistent with the UK study (Waterson et al., 2010), where nine factors reached the best model fit. Other countries found best model fit with less than twelve factors, including Germany, China, France and The Netherlands. However, some countries found support for

the original USA-based twelve-factor solution, including Belgian, Portugal, and Scotland. These diverse findings regarding the dimensionality of the instrument underline the complexity of the multidimensional patient safety culture construct, and suggest the need for carefully considering the national and cultural context when planning the survey-based data collection for both research and intervention purposes on healthcare contexts. Our results should be tested and extended to different healthcare systems by using bigger samples both within and outside Mexico.

5) CONCLUSION

Healthcare faces huge challenges in every country and practitioners deal with an increasing number of patients with complex conditions and comorbidities, which makes even more difficult to provide the best and safest care to every patient (Vincent & Amalberti, 2016). Our results indicate that national and healthcare-specific differences may limit the capacity of the HSPSC to be directly applicable outside of the USA. Our advice for health-care managers and politicians is only using the version of the survey of patient safety culture which has been carefully examined with respect to their psychometric properties and has undergone validation in other contexts either within their own country or with other healthcare systems that are comparable. We hope our study contributes to help key decision-makers on that respect by further adding empirical evidence of the psychometric properties of the HSPSC within the Mexican hospital system, where the survey is still widely underused.

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Table 1. *Nine-Factor Model: Loadings of Exploratory Factorial Analysis for the Hospital Survey on Patient Safety Culture Dimensions.*

<i>item</i>	<i>factor 1</i>	<i>factor 2</i>	<i>factor 3</i>	<i>factor 4</i>	<i>factor 5</i>	<i>factor 6</i>	<i>factor 7</i>	<i>factor 8</i>	<i>factor 9</i>
it 1	0.719								
it 2							(<0.3)		
it 3	0.808								
it 4	0.599								
it 5							0.324		
it 6			0.473						
it 7							(<0.3)		
it 8		0.647							
it 9			0.348						
it 10			(<0.3)						
it 11	0.600								
it 12		0.686							
it 13			0.551						
it 14							0.444		
it 15			0.455						
it 16		0.597							
it 17			(<0.3)						
it 18			0.413						
it 19									0.638
it 20									0.597
it 21							0.583		(<0.3)
it 22							0.657		0.379
it 23				0.635					
it 24				0.699					
it 25				0.763					
it 26				0.630					
it 27				0.558					
it 28				(<0.3)					
it 29					0.815				
it 30					0.970				
it 31					0.766				
it 32									
it 33								0.680	
it 34						0.519			
it 35						0.657			
it 36						(<0.3)			
it 37						0.681			
it 38						0.599			
it 39						0.715			
it 40								0.796	
it 41								(<0.3)	
it 42						(<0.3)			
it 43						0.534			

Note: both the original and the translated items are reported in Appendix 1.

Table 2. *Descriptive Statistics, Correlations among the Hospital Survey on Patient Safety Culture Dimensions, Overall Patient Safety and Number of Reported Events.*

		<i>M</i>	<i>SD</i>	<i>Reliability (α)</i>	1	2	3	4	5	6	7	8	9	10
1	Teamwork within units	3.75	0.81	0.76										
2	Supervisor expectation and action promoting safety	3.50	0.89	0.65	-.112**									
3	Organizational learning	3.38	0.58	unacceptable	.453**	0.05								
4	Overall perception of patient safety	3.45	0.67	unacceptable	.237**	0.03	.273**							
5	Feedback and communication about errors	3.23	0.70	0.64	.406**	-0.07	.400**	.285**						
6	Frequency of events reported	3.40	1.07	0.86	.282**	-.087*	.305**	.253**	.382**					
7	Staffing	2.97	0.68	unacceptable	.269**	.136**	.311**	.179**	.316**	.130**				
8	No punitive response to error	3.70	0.69	unacceptable	.329**	.778**	.233**	.149**	.128**	.083*	.209**			
9	Teamwork across units and hands off and transitions	3.00	0.58	0.62	-.127**	.168**	-0.01	0.07	0.06	-.126**	.179**	0.02		
10	Patient safety	2.58	0.78	Single Item	-.428**	.155**	-.288**	-.303**	-.350**	-.332**	-.181**	-.096*	.236*	
11	Events	1.68	0.90	Single Item	-0.06	.078*	-0.05	-0.03	0.02	-0.07	0.01	0.02	.094*	.170**

** $p < .01$; * $p < .05$

Appendix 1. Spanish translated items and original English version of the Hospital Survey on Patient Safety Culture.

	Spanish translated items	English original items
it 1	En mi área o servicio las personas se apoyan mutuamente	People support one another in this unit
it 2	Tenemos suficiente personal para enfrentar la carga de trabajo	We have enough staff to handle the workload
it 3	Cuando tenemos mucho trabajo, colaboramos todos como equipo para terminarlo	When a lot of work needs to be done quickly, we work together as a team to get the work done
it 4	En mi área o servicio nos tratamos todos con respeto	In this unit, people treat each other with respect
it 5	El personal de esta área trabaja más horas de lo que sería mejor para atender al paciente	Staff in this unit work longer hours than is best for patient care
it 6	Estamos realizando activamente acciones para mejorar la seguridad de los pacientes	We are actively doing things to improve patient safety
it 7	Utilizamos más personal temporal o eventual para mejorar la atención del paciente	We use more agency/temporary staff than is best for patient care
it 8	El personal siente que sus errores son utilizados en su contra	Staff feel like their mistakes are held against them
it 9	Los errores han dado lugar a cambios positivos en mi área de trabajo	Mistakes have led to positive changes here
it 10	En mi área o servicio sólo por casualidad no ocurren errores de mayor gravedad	It is just by chance that more serious mistakes don't happen around here
it 11	Cuando en mi área o servicio alguien está sobrecargado de trabajo, es común que otros le ayuden	When one area in this unit gets really busy, others help out
it 12	Cuando se informa de un incidente, se siente como que se está reportando a la persona y no el problema	When an event is reported, it feels like the person is being written up, not the problem
it 13	Después de que hacemos cambios para mejorar la seguridad del paciente, evaluamos su efectividad	After we make changes to improve patient safety, we evaluate their effectiveness
it 14	Con frecuencia trabajamos como en "forma de crisis" tratando de hacer mucho y muy rápidamente	We work in "crisis mode" trying to do too much, too quickly
it 15	En nuestro servicio la seguridad del paciente nunca se pone en riesgo, por hacer más trabajo	Patient safety is never sacrificed to get more work done
it 16	Al personal de esta área le preocupa que los errores que comete se archiven en su expediente laboral	Staff worry that mistakes they make are kept in their personnel file
it 17	Tenemos problemas con la seguridad del paciente en esta área	We have patient safety problems in this unit
it 18	Nuestros procedimientos y sistemas de trabajo son efectivos para prevenir errores que puedan ocurrir.	Our procedures and systems are good at preventing errors from Happening
it 19	Mi supervisor/jefe hace comentarios favorables cuando el personal realiza el trabajo de acuerdo a los procedimientos de seguridad del paciente establecidos	My supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures
it 20	Mi supervisor/jefe considera seriamente las sugerencias del personal para mejorar la seguridad de los pacientes	My supervisor/manager seriously considers staff suggestions for improving patient safety
it 21	Cuando aumenta la presión de trabajo, mi supervisor/jefe quiere que trabajemos más rápido, aunque ello signifique pasar por alto los procedimientos establecidos para la seguridad del paciente	Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts
it 22	Mi supervisor/jefe no hace caso de los problemas de seguridad del paciente que ocurren una y otra vez	My supervisor/manager overlooks patient safety problems that happen over and over
it 23	Se nos informa sobre los cambios realizados a partir de los incidentes notificados en mi área o servicio	We are given feedback about changes put into place based on event reports
it 24	El personal habla con libertad si ve algo que pueda afectar negativamente la atención del paciente.	Staff will freely speak up if they see something that may negatively affect patient care

it 25	Se nos informa sobre los errores que se cometen en mi área o servicio	We are informed about errors that happen in this unit
it 26	El personal puede cuestionar con total libertad las decisiones o acciones de sus superiores	Staff feel free to question the decisions or actions of those with more authority
it 27	En esta área de trabajo hablamos sobre las formas como se pueden prevenir los errores para que no se vuelvan a cometer	In this unit, we discuss ways to prevent errors from happening again
it 28	El personal tiene miedo de hacer preguntas cuando algo se ha hecho en forma incorrecta.	Staff are afraid to ask questions when something does not seem right
it 29	Cuando se comete un error, pero se detecta y corrige antes de que dañe al paciente, ¿qué tan frecuentemente se reporta?	When a mistake is made, but is caught and corrected before affecting the patient, how often is this reported?
it 30	Cuando se comete un error que se estima que no puede dañar al paciente ¿qué tan frecuentemente se reporta?	When a mistake is made, but has no potential to harm the patient, how often is this reported?
it 31	Cuando se comete un error que se estima podría haber dañado al paciente, pero no lo dañó, ¿qué tan frecuentemente se reporta?	When a mistake is made that could harm the patient, but does not, how often is this reported?
it 33	Asigne un grado de seguridad global del paciente a su área de trabajo	Please give your work area/unit in this hospital an overall grade on patient safety
it 34	La dirección de este hospital proporciona un ambiente laboral que promueve la seguridad del paciente	Hospital management provides a work climate that promotes patient safety
it 35	Las áreas o servicios de este hospital no se coordinan bien entre ellas	Hospital units do not coordinate well with each other
it 36	La información de los pacientes se pierde cuando estos se transfieren de un servicio a otro dentro del hospital	Things “fall between the cracks” when transferring patients from one unit to another
it 37	Hay buena cooperación entre las áreas del hospital que necesitan trabajar juntas	There is good cooperation among hospital units that need to work together
it 38	Con frecuencia se pierde información importante para la atención de pacientes durante los cambios de turno	Important patient care information is often lost during shift changes
it 39	Con frecuencia es desagradable trabajar con personal de otros departamentos del hospital	It is often unpleasant to work with staff from other hospital units
it 40	Con frecuencia surgen problemas en el intercambio de información entre los servicios del hospital	Problems often occur in the exchange of information across hospital units
it 41	Las acciones de la dirección de este hospital muestran que la seguridad del paciente es gran prioridad	The actions of hospital management show that patient safety is a top priority
it 42	La dirección del hospital parece interesada en la seguridad del paciente, solo después de que ocurre un evento adverso	Hospital management seems interested in patient safety only after an adverse event happens
it 43	Los departamentos del hospital trabajan bien juntos, para proporcionar el mejor cuidado a los pacientes	Hospital units work well together to provide the best care for patients