

Table 3 Final six-factor structure for SCS (shared factor structure for NM and MD)

Factor structure (reduced, unambiguous, Nurses and Midwives and Physicians)
<p>Factor 1: Communication culture and support</p> <p>1. The culture of this clinical area makes it easy to learn from the mistakes of others.</p> <p>2. Medical errors are handled appropriately in this clinical area.</p> <p>3. The senior leaders in my hospital listen to me and care about my concerns.[†]</p> <p>4. The doctor and nurse leaders in my area listen to me and care about my concerns.</p> <p>8. I am encouraged by my colleagues to report any safety concerns I may have.^{† ‡ □ §}</p> <p>10. I receive appropriate feedback about my performance.</p> <p>11. I would feel safe being treated here as a patient.^{† §}</p> <p>Factor 2: Organizational safety concerns</p> <p>5. Leadership is driving us to be a safety- centered institution.</p> <p>6. My suggestions about safety would be acted upon if I expressed them to management.</p> <p>7. Management/leadership does not knowingly compromise safety concerns for productivity.[¶]</p> <p>15. This institution is doing more for patient safety now than it did 1 year ago.</p> <p>Factor 3: Clinical leadership</p> <p>14. a. I am satisfied with the availability of clinical leadership: Physician</p> <p>14. b. I am satisfied with the availability of clinical leadership: Nursing</p> <p>14. c. I am satisfied with the availability of clinical leadership: Pharmacy</p> <p>Factor 4: Briefings</p> <p>9. I know the proper channels to direct questions regarding patient safety.^{† □ ‡ □ §}</p> <p>12. Briefing personnel before the start of a shift is an important part of patient safety.</p> <p>13. Briefings are common here.</p> <p>Factor 5: Patient safety promotion</p> <p>17. The personnel in this clinical area take responsibility for patient safety.</p> <p>18. Personnel frequently disregard rules or guidelines that are established for this clinical area.</p> <p>19. Patient safety is constantly reinforced as the priority in this clinical area.</p> <p>Factor 6: Adverse events</p> <p>9. I know the proper channels to direct questions regarding patient safety.^{‡ □ □ §}</p> <p>16. Adverse events occur as a result of system failures/not attributable to one individual's actions.</p> <p>Notes: grey font indicates excluded items (items 3, 8, 9,11)</p> <p>[†]Item loads on a different factor in NM and MD samples.</p> <p>^{‡ □} Ambiguous factor loadings (cross-loadings).</p> <p>[§] Factor loading <0.40.</p> <p>[¶]Theoretically assigned despite of cross-loadings.</p>