SUPPLEMENTARY FILE: QUESTIONNAIRE

Table S1. **Characteristics of Participants.**

Characteristics	**n**	**%**
Professional Title		
Nurse	239	100%
Seniority in the Specialty or Current Profession		
Less than 1 year	42	18%
1 to 2 years	31	13%
3 to 5 years	36	15%
6 to 10 years	71	30%
11 years or more	59	25%
Seniority in the Healthcare Facility		
Less than 1 year	60	25%
1 to 2 years	40	17%
3 to 5 years	52	22%
6 years or more	87	36%
Time Spent in Units		
Less than 50% of your working time	77	32%
50% or more of your working time	162	68%
Participation in Management Committees		
YES	76	32%
NO	163	68%

Table S2. Perception of Staff Regarding Patient Safety, Quality, and the Number of Reported Adverse Events in the Last 12 Months.

Perception of Patient Safety Quality	**Overall Percentage**	**Nurses %**
Excellent	6	3%
Very Good	11	5%
Acceptable	88	37%
Poor	91	38%
Deficient	43	18%
Number of Reported Events	**Overall Percentage**	**Nurses %**
None	206	87%
1 to 2 reports	20	8%
3 to 5 reports	9	4%
6 to 10 reports	1	0%
11 to 20 reports	2	1%
More than 20 reports	1	0%

Table S3. **Results for All Dimensions and Items of the PSC.**

Dimensions of Safety Culture Elements in Hospital Units	**Positive Responses**	**Percentage**
D1: Overall Perceptions of Safety		
Patient safety is never sacrificed to get more work done	76	32%
Our procedures and systems are effective at preventing errors	117	49%
It's by chance that there aren't more serious errors here	66	28%
We have patient safety issues in this facility	74	31%
D2: Frequency of Reported Events		
When an error is made but detected and corrected before affecting the patient, it is reported	134	29%
When an error is made but is not likely to harm the patient, it is reported	89	19%
When an error is made that could harm the patient but does not, it is reported	124	27%
D3: Supervisor or Manager Expectations and Measures to Promote Patient Safety	206	45%
The manager gives positive feedback when they see work done according to established patient safety procedures	210	45%
The manager takes staff suggestions for improving patient safety seriously	181	39%
Every time pressure builds up, my manager wants us to work faster, even if it means cutting corners	186	40%
My manager neglects recurring patient safety issues	248	54%
D4: Organizational Learning and Continuous Improvement		
We take active measures to improve patient safety	103	43%
Errors have led to positive changes here	83	35%
After making changes to improve patient safety, we evaluate their effectiveness	90	38%
We receive feedback on changes implemented based on event reports	29	12%
We are informed about errors that occur in the facility	95	40%
In this facility, we discuss ways to prevent errors from recurring	77	32%
D5: Teamwork within Units		

People help each other in this facility	99	41%
When a lot of work needs to be done quickly, we work together as a team to get it done	134	56%
In this facility, people treat each other with respect	141	59%
When a section of this unit is very busy, others help out	101	42%
D6: Communication Openness		
Staff will speak up if they see something that could harm patient care	84	35%
Staff feel free to question decisions or actions of those in authority	38	16%
Staff are afraid to ask questions when something seems off	101	42%
D7: Non-punitive Response to Errors		
Staff feel that their errors are blamed on them	82	82%
When an event is reported, it feels like the person is written up, not the issue	58	58%
We work in "crisis mode" trying to do too much too quickly	50	50%
D8: Staffing Levels		
We have enough staff to manage the workload	38	16%
Staff in this facility work more hours than is ideal for patient care	65	27%
We work in "crisis mode" trying to do too much too quickly	70	29%
D9: Management Support for Patient Safety		
Management ensures a work environment that promotes patient safety	57	24%
Management actions show that patient safety is a top priority	94	39%
Management only seems interested in patient safety after an adverse event occurs	86	36%
Units work well together to provide the best care for patients	94	39%
D10: Teamwork Between Units		
There is good cooperation between units that need to work together	119	50%
Units do not coordinate well with each other	82	34%
It is often unpleasant to work with staff from other units	92	38%
Things "slip through the cracks" when transferring patients from one unit to another	101	42%

Important information about patient care is often lost during shift changes	105	44%
Problems often arise in the exchange of information between units	76	32%