

Cross-cultural adaptation of the Safety Attitudes Questionnaire Short Form in Spanish and Italian operating rooms: psychometric properties

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ETHICAL APPROVAL INFORMATION

All ethical principles of scientific research in biomedicine were observed, in line with Spanish, Italian, and European legislation on data protection. Informed consent was also sought from all study participants.

This study was approved by the Ethics Committee of the University General Hospital of Castellón (Ethical Approval Number: 2/2017).

In Italy, it was approved by the *Consiglio dei Docenti del Corso di Dottorato di Ricerca in Scienze Infermieristiche e Sanità Pubblica* of the University of Rome "Tor Vergata". An agreement of cultural and direct scientific collaboration between the University of Rome "Tor Vergata" and the Universitat Jaume I of Castellón was also signed.

Permission to translate and test the SAQ-SF was granted by the copyright holder.

ABSTRACT

Objective: The aim of the study was to translate the Safety Attitudes Questionnaire Short Form (SAQ-SF) in Spanish and Italian surgical settings and to assess its psychometric properties.

Method: The cross-cultural adaptation process was performed following the internationally recognized guidelines. A panel of 30 experts evaluated the content validity. Test-retest reliability and internal consistency were evaluated using a cross-sectional design.

Results: The translation process was carried out without relevant difficulties. In Spain, 29 of the 36 SAQ-SF items showed excellent Content Validity Index. In Italy, there were 33 items with an excellent rating. The SAQ-SF's overall Cronbach's Alpha was 0.8 for both countries. Test-retest reliability showed good to very good stability in both in countries.

Conclusions: Italian and Spanish researchers rate differently the same scale, demonstrating the diversity of relevance of the same questions in different countries. A validated questionnaire is now accessible to the Spanish and Italian hospital managements of the National Health Service to measure the safety climate in day-to-day practice in the operating rooms.

Key words: Patient safety; Operating rooms; Safety management; Cross-cultural comparison; Psychometrics.

INTRODUCTION

Research has shown that a strong patient safety culture¹ is essential to provide quality health care and has been the subject of numerous international institutions' research programs aimed at reducing the risk of adverse events^{2,3}.

The first large-scale study on adverse events in patients receiving health care was conducted in 1977, when the California Medical Association found that adverse events had occurred in 4.65% of cases⁴. In the book "To Err is Human: Building a Safer Health System", the United States Institute of Medicine reported that between 44,000 and 98,000 Americans died every year in American hospitals as a result of adverse events, which thus represented the eighth leading cause of death in the population⁵. The data obtained by the authors come from two large previous studies, one conducted in New York in 1984^{6,7} and the other in Colorado and Utah in 1992⁸.

In Europe, studies on patient safety conducted by the Council of Europe, the Organization for Economic Cooperation and Development and the World Health Organization through its World Alliance for Patient Safety prompted the Council of the European Union to issue a Recommendation on patient safety on 9 June 2009, which stated that poor patient safety represents both a severe public health problem and a high economic burden on limited health resources⁹.

In Spain, the *Ministerio de Sanidad, Servicios Sociales e Igualdad* (Spanish initials: MSSSI) has launched the National Health System Patient Safety Strategy, which incorporates the contributions of health professionals and of patients through their organizations^{10,11}. The Ministry has also promoted several epidemiological studies to determine the frequency of adverse events in various health care areas: the ENEAS study on adverse events linked to hospitalization, which found that the incidence of adverse events was 9.3%, of which 42.8% could have been avoided¹², and the APEAS study of adverse events in primary health care, which found that 11.18% of patients experienced an adverse event, of which 64.3% would have been preventable¹³.

In Italy, notable actions carried out by the *Ministero della Salute* (Italian initials: MS) include approval of the *Piano Nazionale Sanitario 2006-2008*, which contains specific references to clinical risk management and patient safety¹⁴; the launch in 2009 of the *Sistema Informativo per il Monitoraggio degli Errori in Sanità, Sanità* (SIMES program) aimed at collecting data on sentinel events¹⁵; and development in 2015 of the *Protocollo per il Monitoraggio degli Eventi Sentinella. 5° Rapporto*, aimed at providing regions with a follow-up and management protocol for sentinel events¹⁶.

One of the many strategies aimed at analyzing or evaluating a construct as complex as patient safety culture is to monitor indicators, which are often measured using questionnaires, whose strengths vary from one to another.

In this paper, we intend to analyze and evaluate a construct as complex as patient safety culture using the Safety Attitudes Questionnaire (SAQ)¹⁷. It is designed to provide a method for evaluating patient safety culture based on two conceptual models: analysis of clinical risk and safety¹⁸ and evaluation of the quality of care¹⁹.

The initial 60 item version of the scale has been adapted for use in intensive care units, operating rooms, primary care, pharmacy services, and delivery rooms. All these versions of the SAQ have maintained the same 31 core items divided into 6 dimensions for all clinical settings. Subsequently, the authors decided to create a generic short version applicable to any service/unit, the Safety Attitudes Questionnaire Short Form (SAQ-SF). This again included the 31 core items divided into 6 dimensions from the original version, with another 5 items deemed useful to describe patient safety attitudes and of value for management teams in hospitals and other services²⁰.

The University of Texas Health Science Center at Houston recommends the SAQ-SF, and typically uses the first 13 items to evaluate the patient safety culture. Various other authors and institutions have also recommended its use due to its proven validity and reliability in different countries, including the United States, Norway, Turkey, Sweden or the Netherlands and its adaptation for use in various health care environments or units, such as intensive care units, operating rooms, primary care, pharmacy services, and delivery rooms³. It has also been used

extensively to explore the relationship between safety climate results and effects on the patient^{21,22}. In light of the above, it was decided to translate, adapt, and validate the short form of the questionnaire for Spanish and Italian operating rooms.

The literature indicated that the content validity of the questionnaire under discussion has been evaluated in Belgium³ and in Switzerland²³. In addition, several studies have calculated the internal consistency of the scale in different settings, obtaining Cronbach's alpha coefficient values of between 0.65 and 0.92 (Portugal, Holland, Denmark, Norway, Switzerland, Sweden, Belgium). Test-retest reliability has only been calculated in one American study on delivery rooms²⁴.

METHODS

Aims

To translate the SAQ-SF in Spanish and Italian surgical settings and to assess the content validity, internal consistency, and test-retest reliability.

Design

A cross-sectional study was conducted both in Spain and Italy using the self-report questionnaire.

Participants and setting

This study was conducted within health care professionals working in Spanish and Italian operating rooms.

Instrument

The SAQ-SF consists of two parts (Figure 1). The first contains 36 items that measure health professionals' behaviors and/or attitudes related to patient safety:

- 1) Teamwork climate (items 1-6). This focuses on perceived quality of collaboration between health care staff to achieve shared objectives.

- 2) Safety climate (items 7-13). This factor examines the degree to which health care professionals identify with their health institution and its goals and values regarding clinical safety.
- 3) Job satisfaction (items 15-19). This refers to health care professionals' level satisfaction and contentment with their health institution.
- 4) Stress recognition (items 20-23). This examines the effect of stressors on the work of health care staff.
- 5) Perception of management (unit management and hospital management) (items 24-28). This focuses on health care professionals' approval of managerial actions and measures.
- 6) Working conditions (items 29-32). It refers to any characteristic (staff, organization, etc.) that may have a significant influence on the generation of adverse events.

Items 14 and 33 to 36 do not form part of the above factors. The second part focuses on additional information related to participants' demographic characteristics.

Translation and cultural adaptation of the SAQ-SF

We conducted a systematic translation process in four stages: 1) forward translation; 2) backward translation; 3) revision of translations by an expert panel; and 4) pretest²⁵⁻²⁹.

Each of the two forward translations was performed by two bilingual translators who were native speakers of the official language of the two participating countries: Spanish in Spain and Italian in Italy. These four people were informed of the study objectives, the questionnaire concepts, and the target population, and had previous experience in translating health care texts. They all worked independently, having received the same information to assure consistent translation of the scale. Subsequently, the translations were compared to identify discrepancies, and these were discussed in order to reach a consensus between the translators and the principal investigator³⁰.

The Spanish and Italian translations were then back-translated into American English by another two bilingual translators who were native speakers of American English. This process was conducted independently. We identified discrepancies between the backward translations,

and consensus was reached to then obtain revised translations of the SAQ-SF into Peninsular Spanish and Italian.

Next, the original version of the instrument and the revised Spanish and Italian versions were assessed to identify semantic errors or inconsistencies and resolve differences between the original questionnaire and the backward translations. To this end, two bilingual people with experience in translating health sciences texts introduced the relevant modifications to the Spanish and Italian versions, to render these were as close as possible to the item wording in the American English original. This yielded the consolidated Spanish and Italian versions.

Lastly, we conducted a pilot study and a cognitive pretest to determine whether the questionnaire worked as originally intended. A minimum of 30 health care professionals from operating room settings in both countries were asked to complete their corresponding questionnaires in paper format or on Google forms and to indicate or annotate any difficulties encountered in the questionnaire or hard to understand questions. In order to know the accuracy of the information imparted, every professional was methodically asked about the questionnaire. Each remark about difficulties were noted and subsequently revised. We identified possible errors and checked that the instructions, items, and response options were easy to understand. Every item was revised when 15% or more of the professionals reported any problem with it. This yielded the definitive versions in Spanish (SAQ-SF_ES) (Figure 2) and Italian (SAQ-SF_IT) (Figure 3).

Assessment of psychometric properties

Content validity

Content validity was evaluated by an expert panel using the content validity index (CVI)^{31,32}. The number of experts can affect the validity of the results, wherefore a minimum number of 5 is established. Nevertheless, to reduce the variance in their answers and to decrease the likelihood that the agreements have not developed by chance, 10 experts are recommended³³⁻³⁶. Therefore, a minimum of 10 experts from each of the health professions involved in surgery, all with at least 5 years' experience in this setting, were identified in each

country: 10 university graduates of nursing, 10 surgeons, and 10 anesthetists. Subsequently, these were formally invited by email to join this study and given a link to the document for completion online. Each expert rated the relevance of each item using a 4-point Likert-type scale: 1=not relevant, 2=somewhat relevant, 3=quite relevant, 4=highly relevant³⁶.

Reliability

Test-retest reliability and internal consistency were assessed using the same 30 health care professionals working in surgical settings.

- Test-retest reliability. As the SAQ-SF is a quantitative scale, it was analyzed by calculating the intraclass correlation coefficient (ICC). The questionnaires were administered at two different times to the same health care professionals who had participated in the cognitive pretest, carrying out the retest after a period of between 2 and 3 weeks³⁷.
- Internal consistency. The correlation of all questionnaire items was measured, assessing the degree of similarity between items, quantified by Cronbach's alpha coefficient (α)³⁸.

Data analysis

The CVI was calculated for each item on the questionnaire (I-CVI) and for the overall scale (S-CVI), taking into account the fact that the I-CVI was calculated as the number of experts giving it a rating of 3 or 4³¹. Items with an I-CVI \geq 0.78 were considered excellent. The S-CVI was calculated as the average I-CVI across items. A value of S-CVI \geq 0.90 was considered evidence of high content validity. Therefore, we also calculated the modified kappa coefficient (κ^*). This determines the degree of agreement on item relevance. Calculating κ^* involves: estimating the probability due to chance: $p_c = [N! / (N! \cdot (N-A)!)] \cdot 0,5^N$, where N is the total number of experts and A is the number of experts who gave a rating of 3 or 4 to each item, and then calculating κ^* using the formula: $\kappa^* = (I-CVI - p_c) / (1 - p_c)$. Next, a set of scores is applied to assess the coefficient κ^* : excellent (>0.74), good (0.60-0.74) and poor (0.59-0.40).

The ICC recommends a minimum standard value of 0.70³⁹, while Cronbach's alpha values should range between 0.70 and 0.90³⁵.

All statistical analyses were performed using IBM SPSS version 22.0, with a significance level of $p < 0.05$.

RESULTS

Translation and cultural adaptation of the SAQ-SF

No problems were encountered with the forward translation, and there were no major differences between translators. However, the most problematic expression in both countries was "*Problem personnel*" in item 27, because it could be translated differently depending on the translator. Following a review of the translation of this item in other countries, including Belgium³, Norway⁴⁰, Holland⁴¹ and Portugal⁴², consensus was reached with the translators concerning the correct translation of this item to ensure semantic and linguistic equivalence.

This process yielded unanimously agreed versions of the questionnaires, which were used to conduct the pilot study and cognitive pretest. All of the 30 experts who were invited to join this study completed the questionnaire, yielding the envisaged sample size in Spain and Italy. Table 1 shows the descriptive analysis of the sociodemographic variables and the bivariate analysis. There were no statistically significant differences when comparing the participants according to country. Participants' comments were analyzed:

- In Spain, 17 of the 30 participants (56.67%) encountered no difficulties or made no comments regarding questionnaire comprehensibility. Two of the surgeons (20%) found that item 40, "My collaboration with pharmacists is good", was not applicable because they do not have any direct contact and therefore no such "collaboration" exists. Neither nurses nor anesthetists commented on this item. It was decided to change the item for "My collaboration with anesthetists is good", since these are the other professionals besides nurses and surgeons who are actively involved in surgery in Spain. In addition, 7 participants (23.33%) observed that including a translation of the expression "in this service" was repetitive and redundant, since the instructions already made it clear that the questionnaire was solely aimed at health care staff working in surgery. Lastly, 6 of the 30 participants (20%) expressed doubts about the term "Problematic staff", alluding to multiple

subjective points of view. We therefore decided to translate the item as “Less efficient staff”.

- In Italy, the participants made no comments and encountered no difficulties in understanding the questionnaire.

Assessment of psychometric properties

Content validity

The content validity value obtained for the Spanish version (S-CVI) was 0.72, while the Italian version obtained a value of 0.82. I-CVI values in both languages ranged between 0.57 and 1.00. The average of the κ^* coefficient was 0.71 (good) in Spanish and 0.82 in Italian (excellent). Of the total number of items in the two versions of the scale (72 items), 86.1% (n=62) obtained an excellent or good rating, and only 10 items obtained a poor rating. These are shown in Table 2, grouped by rating categories.

Reliability

As regards internal consistency, the Spanish version obtained a Cronbach's alpha coefficient of 0.78 for the overall scale. By factor, “Teamwork climate” ($\alpha=0.74$), “Safety climate” ($\alpha=0.76$) and “Working conditions” ($\alpha=0.69$) obtained acceptable values. In the case of the Italian version, the overall scale obtained a value of $\alpha=0.80$. By factor, “Job satisfaction” ($\alpha=0.47$), “Stress recognition” ($\alpha=0.46$) and “Perceptions of management” ($\alpha=0.37$) obtained unacceptable values.

Table 3 gives the results for test-retest reliability for each dimension in both languages. In Spanish, values ranged between 0.70 and 0.92, with the “Perceptions of management” dimension presenting very good reliability. The global ICC for the scale was 0.94 (CI 95%: 0.88-0.98). In Italian, the values ranged between 0.77 and 0.95, with the “Stress recognition” and “Perceptions of management” dimensions presenting very good reliability. The global ICC for the scale was 0.90 (CI 95%: 0.79-0.97).

DISCUSSION

Forward and backward translation of the questionnaire was performed sequentially without incident. However, when the cognitive pretest was conducted, we found that the item referring to pharmacists was not applicable since these had no direct contact with healthcare professionals working in surgery, and that the expression “In this clinical area” was redundant because the questionnaire instructions stated that the instrument was exclusively aimed at health care staff working in operating rooms. All comments made by respondents were addressed, maintaining the version closest in construct and format to the original English version to permit comparability of data.

The results obtained for content validity, assessed by an expert panel, rather than simply replicating standard psychometric tests, confirmed the relevance of the majority of items. The results obtained for content validity of each item (I-CVI) and the modified kappa coefficient κ^* were similar; items that did not fulfill the criteria $I-CVI \geq 0.78$ did not obtain excellent values and vice versa, indicating that both methods yielded the same outcome, supporting the available evidence³.

Only two studies were identified in the literature in which the CVI had been used to calculate the content validity of cross-cultural adaptations of the SAQ-SF, one from Belgium³ and another from Switzerland²³, obtaining values of 0.82 and 0.83 respectively, similar to that obtained for the Italian version.

In sum, the results indicate that most versions of the SAQ-SF contain items with a poor rating. Hence, in order to obtain a better cross-cultural adaptation of instruments, some authors⁴³ have proposed revising or even deleting one or more of the items. Given these results, the CVI may be a good index to evaluate the content validity of the SAQ-SF, due to its robustness, ease of calculation, and compactness. In addition, it focuses on inter-rater agreement on item relevance, providing information both about the overall scale and each of the items.

Our results for test-retest reliability as measured by the ICC were very similar to those obtained in an American study on the delivery room version of the SAQ-SF²⁴, obtaining very good values^{44,45}. It was not possible to compare these results with those reported in other studies

validating psychometric properties because none of them had evaluated this parameter either for the overall scale or for each of the items.

We obtained acceptable results for the internal consistency of the overall scale in both the Spanish and Italian versions; values of α were slightly lower than 0.80, consistent with those reported in other cross-cultural studies^{23,36,46-48}. High item-overall scale correlation values confirm that the process of translation and cultural adaptation had not altered the internal consistency of the questionnaire³⁰.

Nursing managers and researchers need internationally valid measurement tools to compare outcomes of interventions in practice and research⁴⁹. This is the first study to validate a patient safety instrument in Spain and Italy surgical settings, which will certainly impact healthcare professionals' strategies in both countries. Thus, nursing management from both countries could use data that have been generated from the questionnaire to support safety programmes in their organisations to reduce the risk of adverse events²⁹.

In addition, these versions of the SAQ-SF have shown good levels of content validity and internal consistency, making available a validated language version of the questionnaire, it is simple to administer and it can be routinely used in the operating rooms of both countries.

CONCLUSIONS

The process of transcultural translation and adaptation, following several well-established steps, has been a complex process that has involved the collection of information from multiple sources and different empirical evidence, and that has led, finally, to satisfactory results in both countries, Spain and Italy.

The translated and adapted Spanish (SAQ-SF_ES) and Italian (SAQ-SF_IT) versions of the original American questionnaire represent pertinent and applicable tools to evaluate patient safety attitudes in daily surgical practice in Spanish and Italian health system hospitals.

Italian and Spanish researchers rated differently the same scale, demonstrating the diversity of relevance of the same questions in different countries and showing adequate content validity as

well as applicability in the surgical settings, comparable with the original American questionnaire.

The results of this research demonstrate the importance of making a quality cross-cultural adaptation of a questionnaire without compromising its internal consistency and applicability. A more detailed analysis of construct validity would provide the instrument with greater robustness in both surgical contexts. Statistical analyses are currently ongoing, and they will be provided in a future report.

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Table 1.
Descriptive and comparative results of the sociodemographic variables between both countries.

Variables	Spain					Italy					p-Value
	n=30	Minimum	Maximum	Mean	SD	n=30	Minimum	Maximum	Mean	SD	
Sex, n (%):											0.587*
	Female	19 (63.3)	-	-	-	-	21 (70.0)	-	-	-	-
	Male	11 (36.7)					9 (30.0)				
Age, n (%):											0.173**
	< 25 years	-					1 (3.3)				
	25-30 years	5 (16.7)					8 (26.7)				
	31-40 years	12 (40.0)	28	57	41.2	8.53	11 (36.7)	24	55	38	8.87
	41-50 years	9 (30.0)					8 (26.7)				
	> 51 years	4 (13.3)					2 (6.6)				
Position, n (%):											
	Registered nurse	10 (33.33)					10 (33.33)				
	Surgeon	10 (33.33)	-	-	-	-	10 (33.33)	-	-	-	-
	Anesthetist	10 (33.33)					10 (33.33)				
Years in hospital, n (%):											0.290**
	< 1 year	2 (6.7)					2 (6.7)				
	1-5 years	8 (26.7)	0.67	21	10.28	6.36	5 (16.7)	0.75	26	12.45	7.55
	6-10 years	6 (20.0)					7 (23.3)				
	> 10 years	14 (46.6)					16 (53.3)				
Years in the OR, n (%):											0.588**
	< 1 year	3 (10.0)					2 (6.7)				
	1-5 years	9 (30.0)	0.50	32	10.03	9.18	9 (30.0)	0.50	35	11.57	10.35
	6-10 years	10 (33.3)					10 (33.3)				
	>10 years	8 (26.7)					9 (30.0)				

* Mann-Whitney U test.

** Kruskal-Wallis test.

Table 2.
Content validity results for the Spanish and Italian versions of the SAQ-SF.

Subscale	Item	SPAIN (SAQ-SF_ES)				ITALY (SAQ-SF_IT)			
		I-CVI	p _c	k	Rating ^a	I-CVI	p _c	k	Rating ^a
1. Teamwork climate	1	0.63	0.05	0.61	Good	0.67	0.03	0.66	Good
	2	0.60	0.08	0.56	Poor	1.00	<0.01	1.00	Excellent
	3	0.77	<0.01	0.77	Excellent	0.73	0.01	0.73	Good
	4	0.73	0.01	0.73	Good	0.93	<0.01	0.93	Excellent
	5	0.90	<0.01	0.90	Excellent	0.83	<0.01	0.83	Excellent
	6	0.73	0.01	0.73	Good	0.77	<0.01	0.77	Excellent
		S-CVI (subscale 1) = 0.73				S-CVI (subscale 1) = 0.82			
2. Safety climate	7	0.87	<0.01	0.87	Excellent	0.83	<0.01	0.83	Excellent
	8	0.63	0.05	0.61	Good	1.00	<0.01	1.00	Excellent
	9	0.73	0.01	0.73	Good	0.97	<0.01	0.97	Excellent
	10	0.67	0.03	0.66	Good	0.89	<0.01	0.90	Excellent
	11	0.63	0.05	0.61	Good	0.77	<0.01	0.77	Excellent
	12	0.63	0.05	0.61	Good	1.00	<0.01	1.00	Excellent
	13	0.60	0.08	0.56	Poor	0.97	<0.01	0.97	Excellent
		S-CVI (subscale 2) = 0.68				S-CVI (subscale 2) = 0.92			
3. Job satisfaction	14	0.80	<0.01	0.80	Excellent	0.87	<0.01	0.87	Excellent
	15	0.6	0.08	0.56	Poor	0.60	0.08	0.56	Poor
	16	0.6	0.08	0.56	Poor	0.80	<0.01	0.80	Excellent
	17	0.73	0.01	0.73	Good	0.60	0.08	0.56	Poor
	18	0.63	0.05	0.61	Good	0.57	0.11	0.51	Poor
		S-CVI (subscale 3) = 0.67				S-CVI (subscale 3) = 0.69			
4. Stress recognition	19	0.73	0.01	0.73	Good	0.67	0.03	0.66	Good
	20	1.00	<0.01	1.00	Excellent	0.97	<0.01	0.97	Excellent
	21	1.00	<0.01	1.00	Excellent	0.93	<0.01	0.93	Excellent
	22	0.83	<0.01	0.83	Excellent	0.80	<0.01	0.80	Excellent
		S-CVI (subscale 4) = 0.89				S-CVI (subscale 4) = 0.84			
5. Perceptions of management	23	0.73	0.01	0.73	Good	0.87	<0.01	0.97	Excellent
	24	0.93	<0.01	0.93	Excellent	0.89	<0.01	0.90	Excellent
	25	0.73	0.01	0.73	Good	0.67	0.03	0.66	Good
	26	0.67	0.03	0.66	Good	0.93	<0.01	0.93	Excellent
	27	0.73	0.01	0.73	Good	0.70	0.01	0.70	Good
	28	0.63	0.05	0.61	Good	0.63	0.05	0.61	Good
	29	0.63	0.05	0.61	Good	0.70	0.01	0.70	Good
	30	0.57	0.11	0.51	Poor	0.77	<0.01	0.77	Excellent
	31	0.57	0.11	0.51	Poor	0.80	<0.01	0.80	Excellent
	32	0.60	0.08	0.56	Poor	0.73	0.01	0.73	Good
		S-CVI (subscale 5) = 0.68				S-CVI (subscale 5) = 0.77			
6. Working conditions	33	0.93	<0.01	0.93	Excellent	0.87	<0.01	0.87	Excellent
	34	0.73	0.01	0.73	Good	1.00	<0.01	1.00	Excellent
	35	0.70	0.01	0.70	Good	0.89	<0.01	0.90	Excellent
	36	0.73	0.01	0.73	Good	0.83	<0.01	0.83	Excellent
		S-CVI (subscale 6) = 0.78				S-CVI (subscale 5) = 0.90			

I-CVI: Item Content Validity Index; p_c: probability of chance agreement; k: modified kappa coefficient obtained from the proportion of agreement on item relevance.

^a Evaluation criteria of k: poor ≤0.39, weak=0.40-0.59; good=0.60-0.73; excellent ≥0.74; S-CVI: I-CVI average of the items in the subscale.

Table 3.
Reliability results for the Spanish and Italian versions of the SAQ-SF.

Subscale	Item	SPAIN (SAQ-SF_ES)		ITALY (SAQ-SF_IT)	
		ICC	Total alpha of subscale if item is deleted	ICC	Total alpha of subscale if item is deleted
1. Teamwork climate	1	0.98	0.76	0.88	0.79
	2	0.96	0.77	0.94	0.77
	3	0.84	0.76	0.95	0.77
	4	0.90	0.76	0.91	0.77
	5	0.91	0.76	0.93	0.78
	6	0.82	0.75	0.84	0.78
		α (subscale 1) = 0.74		α (subscale 1) = 0.80	
2. Safety climate	7	0.82	0.76	0.90	0.78
	8	0.95	0.76	0.92	0.78
	9	0.83	0.76	0.91	0.79
	10	0.90	0.77	0.92	0.78
	11	0.86	0.75	0.94	0.77
	12	0.84	0.76	0.95	0.78
	13	0.94	0.76	0.94	0.78
		α (subscale 2) = 0.76		α (subscale 2) = 0.78	
3. Job satisfaction	14	0.91	0.78	0.95	0.78
	15	0.96	0.75	0.85	0.78
	16	0.95	0.77	0.86	0.78
	17	0.80	0.77	0.96	0.78
	18	0.81	0.78	0.89	0.80
		α (subscale 3) = 0.35		α (subscale 3) = 0.47	
4. Stress recognition	19	0.98	0.80	0.99	0.81
	20	0.97	0.77	0.96	0.79
	21	0.92	0.79	0.99	0.81
	22	0.95	0.79	0.96	0.78
		α (subscale 4) = 0.58		α (subscale 4) = 0.46	
5. Perceptions of management	23	0.97	0.75	0.84	0.77
	24	0.83	0.78	0.97	0.79
	25	0.95	0.78	0.93	0.79
	26	0.97	0.77	0.98	0.79
	27	0.92	0.77	0.87	0.78
	28	0.96	0.75	0.94	0.79
	29	0.91	0.77	0.89	0.79
	30	0.94	0.76	0.91	0.79
	31	0.90	0.78	0.95	0.80
	32	0.95	0.78	0.91	0.79
			α (subscale 5) = 0.24		α (subscale 5) = 0.37
6. Working conditions	33	0.94	0.76	0.97	0.79
	34	0.97	0.77	0.88	0.79
	35	0.93	0.74	0.97	0.79
	36	0.95	0.76	0.98	0.79
		α (subscale 6) = 0.69		α (subscale 6) = 0.70	

ICC: Intraclass Correlation Coefficient.

Figure 2.
Spanish version of the Safety Attitudes Questionnaire (SAQ-SF_ES).

Actitudes sobre seguridad					
Perspectivas de los profesionales sanitarios que trabajan en quirófano					
Versión Española (SAQ-SF_ES) del Safety Attitudes Questionnaire-Short Form (SAQ-SF)					
<ul style="list-style-type: none"> · Le pedimos su opinión sobre cuestiones relacionadas con la seguridad del paciente en el servicio de quirófano. · Este cuestionario es estrictamente confidencial; todos los datos se gestionarán respetando el secreto estadístico. 					
Por favor, señale con una cruz su grado de acuerdo con las siguientes afirmaciones.					
	A	B	C	D	E
	Muy en desacuerdo	En desacuerdo	Indiferente	De acuerdo	Muy de acuerdo
1. Las iniciativas y/o sugerencias del personal de enfermería son bien recibidas.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Resulta difícil decir lo que se piensa si se percibe un problema en la atención del paciente.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Los desacuerdos que se producen se resuelven de forma apropiada (por ejemplo, no tratar de averiguar quién tiene razón sino qué es mejor para el paciente).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Tengo el apoyo que necesito de otros miembros del personal para atender a los pacientes adecuadamente.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Al personal le resulta fácil hacer preguntas cuando hay algo que no entiende.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Enfermeros/as, cirujanos/as y anestesiólogos/as trabajamos conjuntamente como un equipo bien coordinado.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Me sentiría seguro si tuviera que ser atendido como paciente en quirófano.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. Los errores o eventos adversos se gestionan adecuadamente.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Conozco los canales apropiados para tratar cuestiones relativas a la seguridad del paciente.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. Los comentarios y/u observaciones que recibo acerca del desempeño de mi trabajo son apropiados.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. Es difícil discutir sobre los errores.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. Mis compañeros me animan a comunicar cualquier preocupación que pueda tener sobre seguridad del paciente.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. La cultura existente en quirófano facilita aprender de los errores de otros.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. Mis sugerencias sobre seguridad del paciente se tendrían en cuenta si así las comunicase a la dirección.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. Me gusta mi trabajo.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. Trabajar aquí es como formar parte de una gran familia.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. Este servicio quirúrgico es un buen lugar para trabajar.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. Me siento orgulloso/a de trabajar en quirófano.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. La moral en este servicio es alta.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20. Cuando mi carga de trabajo resulta excesiva, se resiente mi rendimiento.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21. Soy menos eficiente en el trabajo cuando estoy cansado.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22. Es más probable que cometa errores en situaciones tensas u hostiles.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23. El cansancio influye negativamente en mi rendimiento en situaciones de emergencia (por ejemplo, RCP, etc.).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24. La dirección apoya y reconoce mis esfuerzos diarios:			Quiróf <input type="radio"/>		Hosp <input type="radio"/>
25. La dirección no compromete, deliberadamente, la seguridad del paciente:			Quiróf <input type="radio"/>		Hosp <input type="radio"/>
26. La dirección está realizando un buen trabajo:			Quiróf <input type="radio"/>		Hosp <input type="radio"/>
27. La dirección se ocupa del personal menos eficiente de forma constructiva:			Quiróf <input type="radio"/>		Hosp <input type="radio"/>
28. Recibo información puntual sobre imprevistos que puedan afectar a mi trabajo:			Quiróf <input type="radio"/>		Hosp <input type="radio"/>
29. Contamos con el personal suficiente para gestionar el número de pacientes.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
30. Este hospital realiza un buen trabajo en la formación de nuevo personal.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
31. Toda la información necesaria para la toma de decisiones diagnósticas y terapéuticas está a mi disposición de forma habitual.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
32. Los estudiantes en prácticas de mi disciplina son supervisados adecuadamente.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
33. Mi colaboración con los enfermeros/as es buena.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
34. Mi colaboración con el personal médico es buena.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
35. Mi colaboración con los anestesiólogos/as es buena.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
36. Es habitual que se produzcan retrasos en la atención al paciente por problemas de comunicación entre el personal sanitario.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
INFORMACIÓN COMPLEMENTARIA					
37. Sexo:	Mujer <input type="radio"/>	Hombre <input type="radio"/>	38. Edad		
39. ¿En qué año empezó a trabajar en este hospital?	En el año				
40. ¿Cuánto tiempo lleva trabajando en este servicio de quirófano?					
	<input type="radio"/> Menos de un año	<input type="radio"/> De 11 a 15 años			
	<input type="radio"/> De 1 a 5 años	<input type="radio"/> De 16 a 20 años			
	<input type="radio"/> De 6 a 10 años	<input type="radio"/> Más de 20 años			
41. ¿Cuál es su posición laboral en quirófano?	<input type="radio"/> Enfermero/a	<input type="radio"/> Cirujano/a	<input type="radio"/> Anestesiólogo/a		

Muchas gracias por su colaboración.

Figure 3.
Spanish version of the Safety Attitudes Questionnaire (SAQ-SF_IT).

Atteggiamenti nei confronti della sicurezza					
Le prospettive di chi opera in prima linea in sala operatoria Versione Italiana (SAQ-SF_IT) del Safety Attitudes Questionnaire-Short Form (SAQ-SF)					
<ul style="list-style-type: none"> · Le chiediamo la sua opinione in merito a questioni relative alla sicurezza del paziente riguardo l'area operatoria. · Questo questionario è strettamente confidenziale; tutti i dati verranno gestiti rispettando il segreto statistico. 					
Per cortesia, indichi con una "x" una delle risposte indicate nella scala qui di seguito.					
	A	B	C	D	E
	Discordo fortemente	Discordo lievemente	Indifferente	Concordo lievemente	Concordo fortemente
1. Le proposte degli infermieri sono ben accolte.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. È difficile parlare apertamente se percepisco un problema riguardo l'assistenza ai pazienti.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. I disaccordi vengono risolti in modo appropriato (cioè, non conta chi ha ragione ma cosa è meglio per il paziente).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Ho il sostegno necessario di altri membri del personale per prendermi cura dei pazienti.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. È facile per il personale fare delle domande quando c'è qualcosa che non capisce.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Infermieri, chirurghi e anestesisti lavorano insieme come una squadra ben coordinata.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Come paziente mi sentirei al sicuro se venissi curato qui.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. Gli errori o eventi avversi sanitari vengono gestiti appropriatamente.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. So quali siano i canali appropriati per fare domande sulla sicurezza del paziente.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. Ricevo un feedback adeguato sulle mie prestazioni.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. È difficile discutere degli errori.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. Sono incoraggiato dai miei colleghi a riferire qualsiasi perplessità io possa avere sulla sicurezza del paziente.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. La cultura in sala operatoria facilita l'apprendimento dagli errori degli altri.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. I miei suggerimenti sulla sicurezza sarebbero messi in atto se li comunicassi alla direzione.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. Mi piace il mio lavoro.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. Lavorare qui è come essere parte di una grande famiglia.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. Questo è un buon posto dove lavorare.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. Sono orgoglioso/a di lavorare in sala operatoria.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. Il morale in questo servizio/reparto è alto.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20. Quando il mio carico di lavoro diventa eccessivo, ne risente la mia prestazione.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21. Sono meno efficiente nel lavoro quando sono affaticato.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22. Ho più probabilità di commettere errori in situazioni di tensione o ostili.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23. L'affaticamento diminuisce la mia performance durante le situazioni di emergenza (es. rianimazione di emergenza, crisi epilettica).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24. La dirigenza sostiene i miei sforzi quotidiani:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
25. La dirigenza non compromette in modo consapevole la sicurezza del paziente:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
26. La dirigenza sta facendo un buon lavoro:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
27. La dirigenza tratta i membri meno efficienti del personale in modo costruttivo:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
28. Ricevo informazioni puntuali sugli eventi che possono influenzare il mio lavoro:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
29. L'organico in questo servizio/reparto è sufficiente per gestire il numero di pazienti presenti.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
30. Questo ospedale fa un buon lavoro di formazione del nuovo personale.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
31. Tutte le informazioni necessarie per le decisioni diagnostiche e terapeutiche sono disponibili per me di routine.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
32. I tirocinanti della mia disciplina sono adeguatamente supervisionati.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
33. Ho una buona collaborazione con gli infermieri.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
34. Ho una buona collaborazione con i chirurghi.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
35. Ho una buona collaborazione con gli anestesisti.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
36. La mancanza di comunicazione che causa ritardi nell'erogazione delle cure è frequente.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
ULTERIORE INFORMAZIONE					
37. Sesso:	Donna <input type="radio"/>	Uomo <input type="radio"/>	38. Età		
39. In che anno ha iniziato a lavorare in questo ospedale?	Nell'anno				
40. Da quanto tempo lavora in questa sala operatoria?					
<input type="radio"/> Menno di 1 anno	<input type="radio"/> Da 11 a 15 anni				
<input type="radio"/> Da 1 a 5 anni	<input type="radio"/> Da 16 a 20 anni				
<input type="radio"/> Da 6 a 10 anni	<input type="radio"/> Più di 20 anni				
41. Qual è la Sua posizione di lavoro in sala operatoria?	<input type="radio"/> Infermiere/a	<input type="radio"/> Chirurgo	<input type="radio"/> Anestesista		

La ringraziamo per la cortese collaborazione.