

Patient Safety Climate in Danish Primary Care: Adaption and Validation of the Danish Safety Attitudes Questionnaire (SAQ-DK-PRIM) [Response to Letter]

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Dear editor

We have received a letter showing interest in our article titled "Patient Safety Climate in Danish Primary Care: Adaption and Validation of the Danish Safety Attitudes Questionnaire (SAQ-DK-PRIM)" by Juhl et al.¹

We are very happy for the in-depth interest in the topic of patient safety culture, the study and the article. We value the kind and professional recommendations for potential areas for further consideration received from Tien Zubaidah and Norlaila Sofia in Indonesia. We see these to learn from each other and together, and we are pleased for the opportunity to communicate our point-by-point answers in the below.

- 1) The study highlighted that item 5 ("It is difficult to discuss medical errors here") exhibited lower item-rest correlation, which may indicate ambiguity in interpretation. Clarification or modification of such items could enhance overall reliability.
 - The current study was performed in very early days of implementing a national patient safety strategy in primary care in Denmark. In fact, the patient safety culture survey was used as a kickoff the implementation of such an initiative. Thus, the group of invitees could not be expected to have a rich concept of patient safety work in practice or of what a patient safety culture is. We also know from the follow up process where survey results were conveyed and discussed that the group of invitees is complex with some employees not having Danish as their first language, this as well might lead to ambiguity in interpretation of the items. Furthermore item 5 is negatively worded, and we know from previous Danish studies using the Safety Attitudes Questionnaire in hospital care,² that negatively worded items may result in lower item-rest correlation. As such there are several factors which can influence the study results on their own or in an unknown mix of interactions. Under these circumstances, ambiguity in interpretation of the items could be expected to affect the item-rest correlation. Before embarking on modification of the items, we would propose a pilot study to investigate the item-rest correlation for item 5 when it is positively respectively negatively worded.
- 2) Given that 29.4% of the responses were incomplete, future research could explore strategies to optimize participation and completion rates, possibly through digital or simplified data collection tools.
 - This is the first patient safety culture study performed in primary care in Denmark, and we followed the successful practice we had seen in secondary care to obtain a high rate of participation. We did have a high rate of participation, and the rate of incomplete answers could just as well have to do with difficulties in understanding the concept of patient safety or the Danish language. Having said that, we would collect data electronically going forward.

- 3) Broader geographic replication and inclusion of diverse healthcare settings could enrich the external validity and generalizability of the findings.
 - We can only agree that broader geographic replication and inclusion of diverse healthcare settings could enrich the external validity and generalizability of the findings generally. In our study the following context applies: Denmark is a very small country with a primary care sector which is organized very similarly across municipalities. Further, we have a well implemented strong central regulation, and a long tradition of national monitoring of the health care sector. Our study sample is large for a Danish study of this kind and does entail three different settings. We could further have included the general practitioners and the social care institutions, as both are mandated by law to report, investigate and learn from adverse events, thus aiming for improvement of services in the primary care sector and a safer environment for citizens and health care workers. However, these areas are organized under a different management structure, thus we find the current material included in our study sufficient, knowing that we could include data from more municipalities in future studies, and also suggest similar patient safety culture studies among general practitioners and the social care institutions.
- 4) The exclusion of data pertaining to unit-level variances may overlook nuances at sub-organizational levels; addressing this could refine insights into localized safety climates.
 - Thank you for this comment. We agree with you and have seen greater variance across units than across hospitals in another study of patient safety culture in the Danish setting.³ The current study was not large enough to perform such unit sub-organizational level analysis maintaining the anonymity required. However, the results were delivered back to the individual units for review, analysis and follow up. The units performed “patient safety culture audits” a qualitative method to investigate strength and weaknesses of the culture, relate the results to the current practices and establish an improvement plan where deemed needed. Results were presented and discussed across units and management levels. In this way we have taken care of the variance and built an open culture of sharing and learning.
- 5) To obtain better results, we recommend that subsequent studies further examine the role of educational levels and professional backgrounds in safety climate perceptions and employ qualitative approaches to understand deeper contextual factors influencing the responses.
 - Thank you, yes, we would like to examine the role of educational levels and professional backgrounds in safety climate perceptions too.
 - The issue of employing qualitative approaches to understand deeper contextual factors influencing the results has been addressed in the patient safety culture audits applied in the participating units. To our knowledge these factors vary over time and across units.²

Disclosure

There is no conflict of interest to declare related to this communication.

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1. Juhl MH, Olesen AE, Deilkås ET, et al. Patient Safety Climate in Danish Primary Care: adaption and Validation of the Danish Safety Attitudes Questionnaire (SAQ-DK-PRIM). *Clin Epidemiol.* 2024;16:533–547. doi:10.2147/CLEP.S470111
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