Reviewer's report

Title: Characteristics of unit-level patient safety culture in hospitals in Japan: a cross-sectional study

Version: 2 Date: 30 August 2014

Reviewer: Liane Ginsburg

Reviewer's report:

The authors have responded well to the previous review. Overall, it think the paper would be strengthened by giving more attention to the analysis in table 3 on the dimensions contributing to cluster membership in different types of units. This is the unique contribution of this work and so it should be explored in more detail.

The following comments should addressed before the manuscript is published and would be in my view MAJOR COMPULSORY revisions:

1. It is important to state that this study measures ‘perceptions of patient safety culture’ (or patient safety climate) and not actual ‘patient safety culture’ which cannot really be measured by this type of survey. I think that even the AHRQ materials are moving away from calling it PS culture. This requires some rather small, but important, changes to the wording the manuscript in several places.

2. Page 7 – ln 136-137: when you talk about units do you mean unit types? For instance you state that each unit had between 5 and 115 responders and this makes me wonder whether 115 people who may have indicated they work on a “general ward” in one hospital actually work on one of several general wards in that hospital (rather than all on the same ward). If so, then I think you are reporting on respondents from different types of units rather than from different units. Please clarify.

3. Page 7, ln 150 – this paragraph gets equal attention to the subsequent paragraph (p8, ln 161); however the 2nd paragraph (p8, ln 161) describing which dimensions contribute most strongly to high PSC cluster membership for each unit type strikes me as far more useful. Perhaps a bit more time could be spent on these results. For instance, in table 3 – is it possible to include additional columns for long term care and rehab units in this table. Since these 2 unit types get attention elsewhere in the data as being less likely to be high cluster units, it would be instructive to see which dimensions are most likely to predict high PSC cluster membership. See also point 6 below.

4. Table 3 – the column for physician unit looks like hospital management support scores were also predictive of high cluster membership. However, this is not highlighted in table 3.

5. P9, paragraph starting on line 198 – it is still not clear to this reviewer what an
administrative unit is. Are these patient care units? Please provide clarification for international readers regarding the nature of these units. If they don’t provide direct care, then perhaps they should be excluded from these analyses. With other PSC surveys, the items/dimensions are not particularly relevant to staff who do not work in direct care areas and these areas are therefore often excluded from these surveys and analyses. Please describe these units in greater detail and justify their inclusion or remove them.

6. P11, paragraph starting on line 231 – these seem to be some of your most interesting findings (while the findings discussed re LTC in the previous paragraph are interesting, they are less novel). As per my point above, can you discuss in more detail the dimensions that explain cluster membership for some of the different types of units you study. This discussion would help to enhance the contribution your paper makes to the literature.

7. Ln 236 – Please remove or amend statement that it is difficult to establish causation - causation cannot be established with this design.

Level of interest: An article of importance in its field

Quality of written English: Acceptable

Statistical review: No, the manuscript does not need to be seen by a statistician.

Declaration of competing interests:

I declare that I have no competing interests