

# Patient Safety Culture and Incident Reporting in a District Hospital, Indonesia: Nurses' Perspectives

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## ABSTRACT

**Background:** Patient safety culture plays an important role in shaping incident reporting behavior. Incident reporting is a key component of efforts to improve the quality of healthcare services. However, its implementation remains suboptimal, particularly in developing countries. This study aimed to identify the relationship between patient safety culture and incident reporting among nurses.

**Methods:** This cross-sectional study included 328 nurses working in inpatient and intensive care units, with participants selected using a total sampling technique. Data were collected using the Hospital Survey on Patient Safety Culture (HSOPSC) version 2.0 questionnaire. Data were analyzed using descriptive statistics and simple and multiple binary logistic regression analyses.

**Results:** Most respondents (65.5%) had not reported a patient safety incident in the previous 12 months. The average percentage of positive responses regarding patient safety culture was 40.4%, while the positive patient safety grade was 12.5%. All dimensions of patient safety culture were significantly associated with incident reporting ( $p < 0.05$ ). The dimension most strongly associated with incident reporting was response to error ( $p = 0.013$ ; aOR = 1.680; 95% CI = 1.113–2.537).

**Conclusion:** Patient safety culture is a key factor in patient safety incident reporting, particularly the response to the error dimension. Strengthening patient safety culture is essential to improving incident reporting practices and enhancing patient safety in hospitals.

**Keywords:** patient safety culture, incident reporting, nurses

## INTRODUCTION

Patient safety is a fundamental pillar of healthcare systems and a key indicator of healthcare quality, aimed at minimizing the risk of preventable harm during the care process.<sup>1,2</sup> The World Health Organization (WHO) emphasizes that patient safety should be the foundation of all healthcare systems, including national policies, hospital governance, clinical practice, and patient and family engagement.<sup>3</sup> Nevertheless, adverse events remain a significant global issue. Globally, approximately one in ten patients experiences harm during healthcare delivery, and more than three million deaths occur annually due to unsafe care, particularly in low- and middle-income countries. Furthermore, an estimated 134 million adverse events occur each year among patients in hospitals in developing and low-income countries.<sup>2</sup>

Patient safety incident reporting systems have been introduced in about 70% of countries. However, their effectiveness remains limited, and only one-third of countries actively report such incidents.<sup>3</sup> In Indonesia, the patient safety incident reporting system has been implemented nationwide since 2006. Nevertheless, its implementation remains suboptimal, with ongoing underreporting.<sup>1,4</sup> According to the 2021 patient safety incident report from hospitals in Indonesia, a total of 2,272 incidents were reported in the analyzable dataset. The most frequently reported incidents involved medication/intravenous fluids, accounting for 552 cases (24.3%), followed by patient falls with 432 cases (19.0%), and clinical procedures with 301 cases (13.25%). These findings indicate that patient safety incidents in Indonesia continue to occur at a considerable rate. However, the reported figures may not reflect the actual situation due to persistent underreporting.<sup>1</sup>

One of the key strategies for building a strong patient safety system is to report patient safety incidents.<sup>5</sup> Incident reporting systems serve as organizational learning mechanisms for identifying root causes, preventing the recurrence of errors, and strengthening transparency and accountability in healthcare.<sup>2,5-9</sup>

Nevertheless, numerous studies have shown that incident-reporting rates in hospitals remain low.<sup>1,10,11</sup> Nurses, as healthcare professionals with the most direct patient contact, often face barriers to reporting incidents, including fear of punitive consequences, lack of feedback, and the perception that reporting does not lead to meaningful improvements.<sup>6,10</sup>

Patient safety culture is widely recognized as a key determinant of incident reporting behavior.<sup>11,12</sup> A positive patient safety culture can enhance openness and healthcare professionals' willingness to report incidents.<sup>12,13</sup> A culture that promotes openness, effective communication, teamwork, and non-punitive responses to errors has been shown

to increase healthcare professionals' willingness to report incidents without fear of repercussions.<sup>14,15</sup> The Agency for Healthcare Research and Quality (AHRQ) identified ten dimensions of patient safety culture that reflect organizational characteristics that may influence reporting behavior.<sup>16</sup>

Several studies have reported an association between patient safety culture and incident reporting. Positive perceptions of a non-punitive culture and open communication have been shown to increase incident reporting.<sup>14,17,18</sup> However, non-punitive response to error continues to be reported as a weak area in many hospitals and remains a major barrier to incident reporting.<sup>10,11</sup> Nevertheless, empirical findings show variation across organizational and workplace cultural contexts and have not yet provided a comprehensive understanding of which dimensions of patient safety culture are most strongly associated with incident reporting among nurses, particularly in district hospitals in Indonesia.

Based on these gaps, this study aimed to analyze the relationship between patient safety culture dimensions and incident reporting practices and to identify, from nurses' perspectives, the dimension most strongly associated with incident reporting in a district hospital in Indonesia.

## **MATERIALS & METHODS**

This study used a cross-sectional design and was conducted among 344 nurses working in 15 inpatient and intensive care units at a district hospital in Indonesia. The inclusion criteria comprised nurses who had worked for at least six months, were assigned to inpatient or intensive care units, and provided direct patient care. Nurses who were on leave, not actively working, or pursuing further education were excluded from the study. A total sampling technique was used, in which the entire population was included in the study. A total of 328 returned questionnaires were eligible for analysis, resulting in a response rate of 95.3%.

The demographic characteristics assessed included age, gender, educational level, employment status, work unit, length of employment at the hospital, clinical authority level, and participation in patient safety training. Patient safety culture was measured using the Hospital Survey on Patient Safety Culture (HSOPSC) version 2.0, developed by the Agency for Healthcare Research and Quality (AHRQ).<sup>16,19</sup> The questionnaire consists of 32 items grouped into ten major dimensions of patient safety culture, including teamwork, staffing and work pace, organizational learning and continuous improvement, response to error, supervisor support, communication about error, communication openness, reporting patient safety events, hospital management support for patient safety, and handoffs and information exchange. The questionnaire consists of 32 items grouped into ten major dimensions of patient safety culture, including teamwork, staffing and work pace, organizational learning and continuous improvement, response to error, supervisor support, communication about error, communication openness, reporting patient safety events, hospital management support for patient safety, and handoffs and information exchange.<sup>16,19</sup> The instrument demonstrated acceptable reliability, with Cronbach's alpha values ranging from 0.60 to 0.89, and has also been reported to have good discriminant and convergent validity.<sup>20-22</sup> Data were collected using printed questionnaires from September to October 2025. After obtaining ethical approval and permission from the study institution, potential respondents were informed about the study. The researcher distributed the questionnaires after respondents agreed to participate.

### Statistical Analysis

Data analysis used descriptive statistics to examine respondents' demographic characteristics, the frequency of reported patient safety incidents, patient safety grades, and patient safety culture. Descriptive statistics included positive response percentages, frequencies, means, standard deviations, and minimum and maximum values. Patient safety incident reporting responses were dichotomized as "did not report" and "reported." A simple binary logistic regression was used to assess the relationship between patient safety culture and patient safety incident reporting practices at the 95% confidence level ( $p \leq 0.05$ ).

To identify the dimensions of patient safety culture most strongly associated with incident reporting practices, a multiple binary logistic regression was conducted. Before the analysis, model assumptions were assessed using multicollinearity and linearity tests. Model fit was evaluated using the Hosmer–Lemeshow test, model accuracy assessment, and repeated multicollinearity testing. All analyses were conducted at the 95% confidence level.

### RESULT

**Socio-demographic characteristics:** Of the 328 respondents, the majority were female (76.5%), held a Diploma III in Nursing (56.7%), were contract workers (75.9%), were clinical privilege nurses at level I (52.7%), and had never participated in patient safety training (84.8%). The largest proportion of respondents worked in the ICCU and ICU units (9.5%). The average age of respondents was 30.9 years, and the average length of service was 6.41 years (Table 1).

**Table 1. Socio-demographic characteristics**

Demographic characteristics	f	%	Mean	SD	Min	Max
<b>Gender</b>						
Male	77	23,5	-	-	-	-
Female	251	76,5	-	-	-	-
<b>Educational level</b>						
Diploma III in nursing	187	57	-	-	-	-

Demographic characteristics	f	%	Mean	SD	Min	Max
Bachelor of nursing	8	2,4	-	-	-	-
Professional nurse (Ners)	133	40,8	-	-	-	-
<b>Employment status</b>						
Civil servant	60	18,3	-	-	-	-
Government Employees with Employment Agreements (PPPK)	19	5,8	-	-	-	-
Contract employee	249	75,9	-	-	-	-
<b>Unit/work area</b>						
Jeumpa in-patient ward	20	6,1	-	-	-	-
Neurology in-patient ward	23	7,0	-	-	-	-
Pediatric in-patient ward	24	7,3	-	-	-	-
Pavilion in-patient ward	12	3,7	-	-	-	-
Internal medicine in-patient ward	21	6,4	-	-	-	-
Pulmonary in-patient ward	18	5,5	-	-	-	-
Surgical in-patient ward	25	7,6	-	-	-	-
NICU	23	7,0	-	-	-	-
PICU	25	7,6	-	-	-	-
ICCU	31	9,5	-	-	-	-
Urology in-patient ward	14	4,4	-	-	-	-
Cardiac in-patient ward	17	5,2	-	-	-	-
Orthopedic in-patient ward	23	7,0	-	-	-	-
ICU	31	9,5	-	-	-	-
Seulanga in-patient ward	21	6,4	-	-	-	-
<b>Clinical authority level</b>						
Clinical privilege nurse level I	173	52,7	-	-	-	-
Clinical privilege nurse level II	84	25,6	-	-	-	-
Clinical privilege nurse level III	24	7,3	-	-	-	-
Unknown/other (excluding nurses with clinical privilege level IV and V)	47	14,3	-	-	-	-
<b>Patient safety training</b>						
Yes	50	15,2	-	-	-	-
No	278	84,8	-	-	-	-
<b>Age</b>	-	-	30,90	6,54	22	51
<b>Length of employment</b>	-	-	6,41	6,09	1	29

**Patient safety culture:** Among the dimensions of patient safety culture, teamwork had the highest mean score (3.61), whereas reporting patient safety events had the lowest (2.11) (Table 2). The

average percentage of positive responses across the patient safety culture dimensions was 40.4% (Figure 1), whereas the positive patient safety grade was 12.5% (Figure 2).

**Table 2. Patient safety culture**

Dimensions	Mean	SD	Min	Max
Teamwork	3,61	0,89	1,33	5,00
Staffing and work pace	3,20	0,78	1,50	4,75
Organizational learning-continuous improvement	3,18	0,99	1,33	5,00
Response to error	2,17	1,07	1,00	4,75
Supervisor, manager, or clinical leader support for patient safety	3,24	0,93	1,00	5,00
Communication about error	3,01	1,16	1,00	5,00
Communication openness	2,62	1,01	1,00	5,00
Reporting patient safety events	2,11	1,23	1,00	5,00
Hospital management support for patient safety	2,56	0,88	1,00	5,00
Handoffs and information exchange	2,99	0,90	1,00	5,00

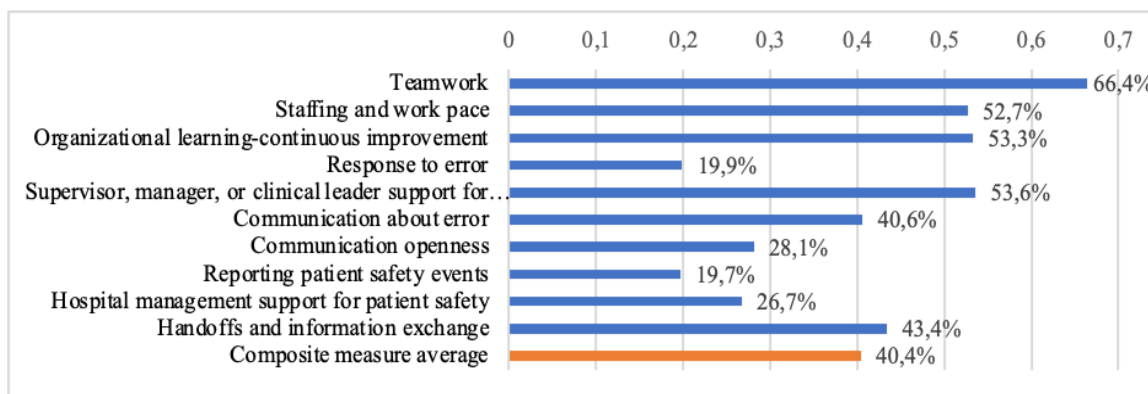


Figure 1. Average percent positive response for patient safety culture dimensions and composite measures

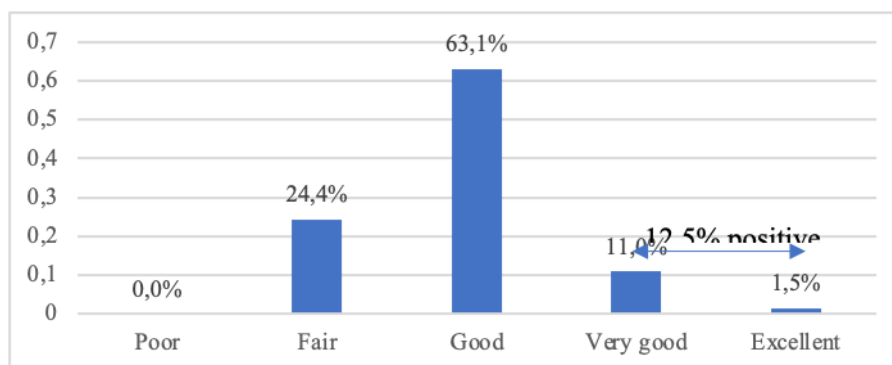


Figure 2. Average percentage response on unit/work area overall rating on patient safety

**Incident reporting practices:** 65.5% of respondents had not reported a patient safety incident in the previous 12 months (Table 3), and the average positive response rate for incident reporting was 34.5% (Figure 3).

Table 3. Patient safety incident reporting practices

Category	f	%
Did not report	215	65,5
Reported	113	34,5

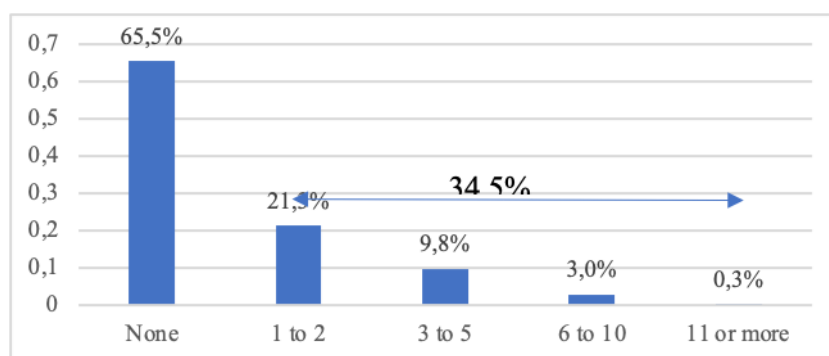


Figure 3. Average percentage response for the number of patient safety events reported in the past 12 months

**Relationship between patient safety culture dimensions and incident reporting practices:** All patient safety

culture dimensions were significantly associated with incident reporting practices ( $p < 0.05$ ) (Table 4).

**Table 4. Relationship between patient safety culture dimensions and incident reporting practices**

Dimensions	Crude OR	95% CI	p
Teamwork	2,578	1,863–3,567	< 0,001
Staffing and work pace	2,774	1,978–3,892	< 0,001
Organizational learning-continuous improvement	2,423	1,850–3,173	< 0,001
Response to error	2,433	1,906–3,107	< 0,001
Supervisor, manager, or clinical leader support for patient safety	2,123	1,603–2,813	< 0,001
Communication about error	1,961	1,576–2,441	< 0,001
Communication openness	2,415	1,871–3,117	< 0,001
Reporting patient safety events	2,746	2,165–3,481	< 0,001
Hospital management support for patient safety	2,311	1,735–3,078	< 0,001
Handoffs and information exchange	1,555	1,195–2,024	0,001

**Dimensions most strongly associated with incident reporting practices:** Seven independent variables that met the assumptions of multicollinearity and linearity were included in the multiple

binary logistic regression model. The results showed that the response to the error dimension was the factor most strongly associated with patient safety incident reporting practices (Table 5).

**Table 5. Factors most strongly associated with incident reporting practices**

Independent variables	aOR (Exp-B)	95% CI	p
Teamwork	1,452	0,971 – 2,173	0,069
Organizational learning-continuous improvement	1,248	0,798 – 1,952	0,331
Response to error	<b>1,680</b>	<b>1,113 – 2,537</b>	<b>0,013</b>
Communication about error	1,035	0,712 – 1,503	0,858
Communication openness	1,381	0,834 – 2,288	0,210
Hospital management support for patient safety	0,870	0,538 – 1,409	0,572
Handoffs and information exchange	0,832	0,594 – 1,165	0,284

## DISCUSSION

The findings of this study demonstrated that all dimensions of patient safety culture were associated with nurses' incident reporting practices, with the response to error dimension showing the strongest association. These findings indicate that although various dimensions of patient safety culture contribute to reporting behavior, nurses' perceptions of how organizations respond to errors constitute a key factor influencing incident reporting practices. The high proportion of nurses who did not report incidents (65.5%) within the previous 12 months indicates that underreporting remains a substantial issue. This suggests that the existing reporting system has not fully created a sense of psychological safety for healthcare professionals. In this context, organizational responses to errors become particularly crucial, as they directly influence incident reporting behavior.

The finding that the response to error dimension was the factor most strongly associated with nurses' patient safety incident reporting practices suggests that this dimension has a stronger influence than the other dimensions. This may be explained by the fact that, although other dimensions are important, they are insufficient to encourage incident reporting when healthcare professionals continue to fear negative consequences. In other words, a non-punitive culture appears to be a fundamental prerequisite for other dimensions of patient safety culture to function optimally.

These findings are consistent with previous studies indicating that dimensions of patient safety culture, including teamwork, staffing and work pace, organizational learning-continuous improvement, response to error, supervisor support, communication about error, communication openness, reporting patient safety events, hospital management support for patient safety, and handoffs and

information exchange, are important determinants of improved incident reporting practices.<sup>11,12,14</sup>

Studies have shown that a weak patient safety culture can reduce openness and trust in reporting.<sup>23</sup> These findings are consistent with previous studies showing that patient safety culture remains moderate, and nearly half of respondents have never reported a patient safety incident.<sup>24</sup> Furthermore, several studies have emphasized that cultural factors, particularly the response to error, are among the primary determinants of improved incident reporting across various healthcare settings.<sup>6,25,26</sup>

Other studies have shown that a non-punitive patient safety culture is linked to increased incident reporting.<sup>14</sup> Conversely, a culture marked by blaming individuals, fear of punishment, and a lack of feedback may reduce openness in reporting incidents.<sup>10,11</sup> Furthermore, the findings of this study are consistent with previous research showing that organizational responses to errors strongly influence healthcare professionals' willingness to report incidents. A supportive environment can enhance trust and openness in incident reporting.<sup>12,27</sup>

Fear of punishment, sanctions, stigma, and negative career consequences are major barriers to incident reporting. Healthcare professionals tend to avoid reporting errors when organizational responses are perceived as punitive and blaming.<sup>10,28</sup> Response to error is an essential component of patient safety culture, particularly within the concept of just culture, which emphasizes balancing individual accountability with system learning. Within a just culture framework, errors are viewed as opportunities for learning rather than as individual failures, thereby promoting incident reporting.<sup>15,17,23</sup> Studies have shown that work environments that implement a just culture and avoid individual blame significantly increase willingness to report incidents and strengthen trust in reporting systems.<sup>2</sup> Furthermore, other studies have shown that

perceptions of fair and non-punitive organizational responses improve compliance with patient safety incident reporting.<sup>14,29</sup>

Hospitals need to develop policies that emphasize non-punitive approaches, including anonymous reporting systems, constructive feedback mechanisms, and patient safety culture training grounded in just culture principles. Hospitals play a strategic role in fostering supportive, open environments for incident reporting. This is supported by previous studies demonstrating that training programs designed to strengthen the role of head nurses can reinforce dimensions of patient safety culture and improve incident reporting behavior.<sup>30</sup> This study has several limitations, particularly regarding the study setting, as it was conducted in only one hospital, limiting the generalizability of the findings.

## CONCLUSION

The findings of this study indicate that all dimensions of patient safety culture were associated with nurses' reporting of patient safety incidents, with the response to error dimension identified as the most strongly associated factor. These findings highlight that a non-punitive culture is essential to promote openness and encourage incident reporting. The low rate of incident reporting suggests that cultural barriers within the patient safety system persist. Therefore, hospitals need to strengthen the implementation of just culture principles, provide safe reporting systems, and enhance feedback mechanisms for incident reports to improve patient safety.

### *Declaration by Authors*

**Ethical Approval:** This study was approved by the Research Ethics Committee of the Faculty of Nursing at Universitas Syiah Kuala (Document Number: 112022250825; Date: September 1, 2025).

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**Conflict of Interest:** The authors declare no conflicts of interest with respect to this study.

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