



THE RELATIONSHIP BETWEEN PATIENT SAFETY INCIDENT REPORTING CULTURE AND THE IMPLEMENTATION OF THE SIX PATIENT SAFETY GOALS IN PRIMARY HEALTHCARE FACILITIES

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ABSTRACT

The Patient Safety Incident Reporting Culture (IKP/KNC) is important and required to improve service quality and patient safety. Through open, non-blaming reporting, healthcare professionals are encouraged to report incidents, enabling organizations to conduct root-cause analyses, implement system improvements, and prevent recurrences. Ultimately, this reduces clinical risk, improves service practices, and builds trust among patients and their families. This study aimed to analyze the relationship between the IKP reporting culture and the implementation of six (6) patient safety standards (6 SKP) in accredited First-Level Healthcare Facilities (FKTP) in East Java. This research was an analytic quantitative study using a cross-sectional design. The sample consisted of 62 respondents, selected using a purposive random sampling method. The independent variable was the IKP reporting culture, while the dependent variable was the implementation of the 6 SKP. The research instrument used a Likert scale. Validity testing showed $r = 0.50-0.68$ ($p < 0.05$), and reliability measured by Cronbach's Alpha was 0.84. The analysis was conducted using Spearman's test with SPSS version 23. The respondents comprised 80.6% women, 59.7% aged >45 years, 50% with bachelor's degree (S1), 87.1% with >5 years of employment, 50% having received patient safety training, 91.9% from facilities with full accreditation, and 59.7% who had never reported an IKP. The IKP reporting culture was categorized as good (88.70%) and fair (11.29%), whereas the implementation of the 6 SKP was good (98.39%) and fair (1.61%). There was a strong and significant positive relationship between the IKP reporting culture and the implementation of the 6 SKP ($\rho = 0.745$; $p < 0.001$; $n = 62$).

Keywords: IKP/KNC reporting culture; implementation of the 6 SKP; patient safety

INTRODUCTION

Patient safety is a primary indicator of healthcare quality in Primary Healthcare Facilities (PHCs), which serve as the frontline of healthcare services. High patient volume, complex care dynamics, resource limitations, and variations in healthcare worker competencies in PHCs act as triggers that increase the risk of Patient Safety Incidents (PSIs). These incidents encompass Near-Misses (KNC), No-Harm Incidents (KTC), and Adverse Events (KTD).

A robust culture of reporting Patient Safety Incidents (PSIs) is vital to improving patient safety and quality of care. The World Health Organization (WHO) states that 1 in 10 patients experiences harm during care, and nearly 50% of these incidents are preventable. In 2019, the Ministry of Health of the Republic of Indonesia noted that East Java contributed 13% of national incident reports, which consisted of 75% no-harm incidents, 16% mild injuries, 5% moderate injuries, 1.8% severe injuries, and 2.3% fatalities. Out of these, Near-Misses accounted for 38% and Adverse Events accounted for 31%.

Furthermore, evaluations in 2024 revealed that the reporting culture in PHCs remains sub-optimal. Consequently, the risk of underreporting causes safety issues to go undetected, leading to a decline

in service quality and public trust. A PSI/Near-Miss reporting culture is a core component of a patient safety culture needed to identify, analyze, and rectify incidents; however, reporting practices in PHCs remain low. Many healthcare professionals are reluctant to report due to fear of blame, sanctions, and damage to their professional reputation. As a result, the incident data does not reflect reality, and opportunities for system improvement remain limited. This condition triggers underreporting, causing organizations to lose the opportunity to learn from root causes and prevent recurring events. (Daud, A. W., 2020)

PHC accreditation mandates the implementation of the Six National Patient Safety Goals (NPSGs) to enhance service quality. Implementing these 6 NPSGs requires strong commitment from healthcare professionals and robust safety culture support, including a reporting culture. Without a proper reporting system, evaluating the 6 NPSGs objectively and sustainably becomes difficult. Data from the World Health Organization (WHO) indicates that 1 in 10 patients suffers harm during care, 50% of which is preventable (Tutiany, L. P., 2017). In 2019, East Java accounted for 13% of national PSI reports, with Near-Misses at 38% and Adverse Events at 31% (Daud, A. W., 2020). An evaluation conducted by the Ministry of Health in 2024 found that the reporting culture in PHCs was neither optimal nor evenly distributed, compounded by digital transformation challenges and rising public scrutiny regarding healthcare quality (Permenkes RI Nomor 11 Tahun 2017); (World Health Organization, 2023).

Various prior studies have proven that patient safety culture is associated with the reporting of patient safety incidents and the attitudes of healthcare professionals toward reporting. However, most research still focuses on hospital environments and has not specifically examined the relationship between the reporting culture of Patient Safety Incidents (PSIs) / Near-Misses and the implementation of the six National Patient Safety Goals in Primary Healthcare Facilities (PHCs). This study is crucial to bridge this knowledge gap and provide empirical evidence regarding the role of reporting culture in supporting the implementation of Patient Safety Goals in accredited PHCs (Martin, G. et al., 2019). Based on these points, research is needed to examine the relationship between the reporting culture of Patient Safety Incidents (IKP) / Near-Miss Events (KNC) and the implementation of the Six Patient Safety Goals in accredited primary health care facilities (FKTP) in East Java, in order to strengthen efforts to improve quality and patient safety. Research Benefits: To enhance a patient safety culture by strengthening the reporting culture for Patient Safety Incidents (IKP) and Near-Miss Events (KNC), and to develop materials for strategies for coaching and mentoring accreditation, so that FKTP can be more optimal in implementing a patient safety system oriented toward improving service quality. The purpose of this research is to determine the relationship between the incident reporting culture of patient safety and the implementation of the Six Patient Safety Goals in primary health care facilities.

METHOD

This study used a quantitative analytic research design with a cross-sectional data collection approach. The research period was from 25 April to 25 May 2025. Population: all health workers working at accredited primary health care facilities (FKTP) in East Java. Sample: 62 respondents who met the inclusion criteria. Sampling technique: *purposive random sampling*. Respondents also agreed to participate and provided informed consent. Data was collected from 62 respondents. Research Variables, and Independent Variable: the reporting culture for Patient Safety Incidents (IKP) / Near-Miss Events (KNC) and Dependent Variable: the implementation of the Six Patient Safety Goals (6 SKP) (Creswell, J. W., 2016) Questionnaire and Data Analysis. The instrument used in this questionnaire was a Likert scale. Scores were obtained by summing respondents' answers and then calculating percentages. Categorization was as follows: Good: 76–100; Fair: 56–75; Poor: ≤ 55 . The questionnaire was reliable.

Validity and Reliability Tests

Validity: all items had $I\text{-CVI} \geq 0.83$ and $S\text{-CVI/Ave} = 0.91$, indicating the items were valid. In total, 33 questionnaire items were tested using point-biserial correlation, with $r = 0.50\text{--}0.68$ ($p < 0.05$), indicating the items were valid. Reliability: Cronbach's Alpha = 0.84, indicating the instrument was reliable. Research Ethics. All respondents who participated in this study provided approval by signing an informed consent document.

RESULT AND DISCUSSION

The results of the study show that, based on the respondents' characteristics by gender, the majority were women, accounting for 80.6%. In terms of age, 59.7% of respondents were over 45 years old. Regarding educational level, most respondents had a Bachelor's degree (S1). For length of work, 87.10% had worked for more than 5 years. Regarding safety training, 50% of respondents had participated in safety training, while 50% had not. In addition, 91.9% had paripurna accreditation. For the occurrence of incidents, 59.7% reported that no incidents had occurred in the last five years. Further details can be seen in table 1.

Table 1.
Respondent Characteristics

Variable	Category	f	%
Gender	Male	12	19,4
	Female	50	80,6
Age	> 45	37	59,7
	35-44	13	21,0
	25-34	12	19,4
Education	S2	17	27,4
	S1	31	50,0
	D3	14	22,6
Length of work	>5 years	54	87,1
	≤ 5 years	8	12,9
Patient safety training	Yes	31	50,0
	No	31	50,0

From the perspective of reporting, the reporting culture of primary health care facilities (FKTP) in East Java shows a percentage of 88.70% in the good category and 11.30% in the fair category, while the poor category is none (0%). This indicates that the reporting culture of FKTP in East Java is already quite good. Meanwhile, based on the frequency of implementation of the Six Patient Safety Goals (6 SKP), the implementation of 6 SKP in FKTP in East Java is as follows: 98.39% in the good category and 1.61% in the fair category. This suggests that the implementation of the Six Patient Safety Goals (6 SKP) in East Java is also quite good. For more details, see table 3.2.

Table 2.
Frequency of Reporting Culture and Implementation of the Six Patient Safety Goals

Category	Reporting Culture		Implementation of the Six Patient Safety Goals	
	(n)	(%)	(n)	(%)
Good	55	88,70	61	98,39
Fair	7	11,30	1	1,61
Poor	0	0	0	0

This study indicates that patient safety training and the occurrence of patient safety incidents occur in all FKTP across all accreditation statuses, with percentages that are nearly balanced. This means that the risk must be mitigated by developing a reporting culture for Patient Safety Incidents (IKP), as well as providing patient safety training and addressing patient safety incident occurrences across all FKTP and among all health workers. This finding is not related to the length of employment, as the percentages are nearly balanced; therefore, the risk should be mitigated by strengthening the IKP reporting culture.

Table 3.
Distribution of Safety Training and Accreditation Status Regarding Incidents

Accreditation Status	safety training	Incident		Total
		Never	Ever	
Full	Completed	15	13	28
	Not completed	20	9	29
	Total	35	22	57
Main	Completed	1	0	1
	Not completed	0	1	1
	Total	1	1	2
Middle	Completed	0	1	1
	Total	0	1	1
Pratama	Completed	0	1	1
	Not completed	1	0	1
	Total	1	1	2
Total	Completed	16	15	31
	Not completed	21	10	31
	Total	37	25	62

Table 4.
Distribution of length of service and safety training for incidents

Incident			Pelatihan safety		Total
			Yes	No	
Never	Length of employment	> 5 years	15	18	33
		≤ 5 years	1	3	4
	Total		16	21	37
Ever	Length of employment	> 5 years	11	10	21
		≤ 5 years	4	0	4
	Total		15	10	25
	Length of employment	> 5 years	26	28	54
		≤ 5 years	5	3	8
	Total		31	31	62

The Relationship between Reporting Culture and the Implementation of 6 SKPs

Table 5.
Cross-tabulation of the IKP reporting culture variable with 6 SKP categories

		Safety		Total
		Good	Fair/ Moderate	
Culture	Good	54	1	55
	Fair / Moderate	7	0	7

There is a strong and significant positive relationship between the IKP reporting culture and the implementation of the 6 SKP ($p=0.745$; $p<0.001$; $n=62$). The better the reporting culture, the better the implementation of the 6 SKP.

The results of the study showed that the majority of respondents, 80.6%, were female, aged >45 years (59.7%), had a bachelor's degree (50.0%), had worked for >5 years (87.1%), had attended patient safety training (50%), had completed accreditation status (91.9%) and had never had an incident (59.7%) in the last 5 years. These research findings align with WHO recommendations stating that healthcare organizations possessing a strong culture of incident reporting are better positioned to identify root causes, engage in organizational learning, and continuously develop system improvements. They provide the latest global data on patient safety incidents and highlight the urgency of establishing a safety culture across all levels of healthcare, while reinforcing the importance of patient safety and incident-based learning (WHO, 2023), (WHO, 2023 a) (WHO, 2024). WHO also identifies the development of incident reporting and learning systems as a key

strategy for enhancing the quality of healthcare services through learning from every patient safety incident.

The results of this study support various recent studies showing that patient safety culture is positively associated with healthcare workers' adherence to patient safety standards, including incident reporting and implementation of patient safety goals. Machado C.F.T., et al., reviewed safety culture in primary care and organizational factors influencing patient safety implementation (Machado C.F.T., et al, 2025). Safety culture interventions and team discussions increased incident reporting in primary care (Verbakel N.J., et al, 2020) Miller N., et al., 2021, demonstrated that a better safety culture is associated with increased voluntary incident reporting in outpatient and primary care settings (Miller N., et al, 2021)

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Reporting culture describes health workers having awareness, openness, and courage to report every incident or potential patient safety incident as an effort to learn and improve the quality of service. According to Alsobou N., et al. (2025) Explaining the relationship between patient safety culture and the attitude of health workers in reporting incidents (Alsobou N., et al., 2025) further related to reporting culture is the results of the study showing a culture of concern for reporting that is in accordance with the characteristics of the respondents, namely the majority of female respondents who have had longer working experience due to their higher education levels and have had patient safety training (Fadhillah, H. et al, 2018)

The reporting culture at First-Level Healthcare Facilities (FKTP) in East Java falls into the *good* category at 88.70% and the *fair* category at 11.29%. The assessment results of the reporting culture for the Indicator of Patient Safety Culture (IKP) in FKTP show that there are no longer any facilities in the *poor* category, because the mean score is 86.17, which places it in the *good* category. However, with a standard deviation of 9.772, there are still several FKTP facilities whose reporting culture is classified as *fair*. A *good* reporting culture is characterized by a work environment that supports open communication, does not blame individuals (non-punitive culture), provides leadership support, and has a reporting system that is easily accessible and understood by healthcare workers. Reporting is carried out without fear and is regarded as part of professional responsibility. (Evie Sulahyuningsih, D. T., 2017) Kaya et al. (2023) show that the results indicate that a strong patient safety culture is associated with increased incident reporting and better patient safety assessments. (Kaya et al, 2023)

The assessment results of the implementation of the six SKP at First-Level Healthcare Facilities (FKTP) in East Java show that the implementation of the six SKP is categorized as *good* at 98.39% and *fair* at 1.61%. There are no facilities in the *poor* category. The mean score is 90.70, which places it in the *good* category. However, with a standard deviation of 8.342, there are still several FKTP facilities whose reporting culture is classified as *fair*. A strong patient safety culture is characterized by open communication, a non-punitive environment, and organizational support for incident reporting. Various barriers—such as fear of blame, fear of sanctions, and low awareness of reporting—lead to underreporting of patient safety incidents (Hadi, I., 2017). Therefore, commitment from all parties is required to create a safe, open reporting culture that is oriented toward learning in order to improve the quality of services and patient safety at FKTP. This means that risks must be mitigated by developing the IKP reporting culture.

A good reporting culture is not oriented toward punishing individuals, but instead focuses on: system evaluation, identification of root causes, and preventing the recurrence of incidents. Errors are viewed

as opportunities for organizational learning. Staff feel safe to express opinions and to report incidents. (Karmila, Suharni, & Alwi, M. K., 2023). The analysis results show a strong and statistically significant positive relationship between the reporting culture of IKP and the implementation of the six SKP ($\rho = 0.745$; $p < 0.001$; $n = 62$). The better the reporting culture for IKP/KNC, the better the implementation of the six SKP. Respondents have carried out the standard elements of the accreditation assessment as a work culture aimed at improving the quality of services at FKTP.

“Each incident report is used as material for: evaluation, root-cause analysis, improvement of procedures, and enhancement of service quality. The organization learns from incidents to prevent similar events. FKTP facilities with a good reporting culture generally show more effective team communication, more optimal patient safety implementation, better implementation of the Six Patient Safety Goals (6 SKP), and improved service quality. The Patient Safety Culture reporting indicators for IKP/KNC which include the frequency of incident reporting, openness of communication, non-punitive responses to errors, leadership support, feedback on reports, and organizational learning (Hadi, I., 2017). indicate that the better these indicators are, the stronger the patient safety culture within the healthcare service organization.” In this study, the relationship between the reporting culture of IKP/KNC and the implementation of the six SKP in accredited FKTP was examined to assess the extent to which patient safety standards have been applied by health workers in daily services.

The findings indicate an increase in the literacy of health workers in applying accreditation standard assessment elements. The leadership support of FKTPs is very strong in efforts to implement the IKP reporting culture and to develop a PDCA system for continuous quality improvement, including support from the District/City Health Office through scheduled and ongoing guidance by the TPCB team. Most accredited FKTPs have implemented patient identification procedures, although staff compliance is sometimes not consistent—especially when the service workload is high—so that, in the last five years, about 10% of reported IKP were identified as incidents due to incorrect administration of medication, incorrect actions, and errors in patient examinations. Barriers are still found, such as suboptimal communication between professions and incomplete documentation (for example, communication issues, errors in providing therapy, and delays in service delivery). Most FKTPs have a system for managing high-alert medications, but limitations were still identified in labeling and monitoring the use of certain medications. Patient verification procedures have generally been implemented, especially for simple invasive procedures; however, documentation is sometimes not optimal, so cases of wrong actions, wrong patients, and service-related complications still occur. Accredited FKTPs generally have PPI (infection prevention and control) programs, but compliance with hand hygiene and the use of personal protective equipment (PPE) still varies, leading to healthcare-associated infections, disease transmission, and an increased risk to patient and staff safety. Implementation of fall-risk prevention in FKTPs is generally simpler than in hospitals, but it remains important—particularly for elderly patients, children, and patients with physical limitations—to prevent patient injuries, trauma, and additional complications. Nevertheless, statistically, the results show a strong and significant positive relationship between the IKP reporting culture and the implementation of the six SKP in accredited FKTPs in East Java.

The relationship between the IKP/KNC Reporting Culture is closely related to the implementation of the six SKP. Good incident reporting enables FKTPs to identify weaknesses in the application of the SKP, evaluate service errors, take corrective actions, and improve service systems continuously, because the organization actively engages in learning and quality improvement. Conversely, a low reporting culture can lead to underreporting of incidents, weak patient safety evaluation, and suboptimal implementation of the six SKP. These findings support the assumption that a good IKP/KNC reporting culture can contribute to the success of implementing Patient Safety Goals in healthcare facilities. (Lee, Y. mi and Oh, H. , 2020)

The results of this study are consistent with previous research conducted in hospitals, published in a journal by Karmila, Suharni, and Muhammad Kidri Alwi, which showed that patient safety culture is associated with the reporting of patient safety incidents ($p = 0.009 < \alpha = 0.05$). Alfiani, Artiawati, and Wulandari (2018) found that the reporting of patient safety incidents is influenced by both individual and organizational factors. Individual factors include the level of education, length of employment, knowledge of patient safety, fear of being blamed, stress, and the willingness to report. Meanwhile, organizational factors include the patient safety culture, incident reporting systems, collaboration between units, and the response to incident reports. (Alfiani, F., Artiawati, I.R. and Wulandari, R.Y., 2018).

Amanian et al. (2020), in a systematic review on patient safety incidents in emergency departments, found that organizational and management factors—including incident reporting systems, communication, and teamwork—significantly contribute to the occurrence of patient safety incidents. (Amanian, S. et al., 2020). Wigati found that there is an influence of the Patient Safety Culture on the attitude toward reporting patient safety incidents at Nirmala Suri Hospital, Sukoharjo. (Wigati tri and MI., 2020) Additionally, a study on primary care by Chanelière et al. (2024) demonstrated that training programs, the appointment of designated risk officers, and multidisciplinary discussions significantly increased incident reporting and were highly suitable for primary healthcare facilities (Chanelière, M., et al, 2024). Furthermore, research by Gens-Barberà et al. (2021) explained how electronic reporting systems assist in identifying incident patterns for quality improvement (Gens-Barberà et al., 2021). Furthermore, Mutia and Dhamanti (2023) reviewed patient safety culture measurement instruments (HSOPSC, MOSPSC, and SAQ) and highlighted the importance of a non-punitive response, management support, and the frequency of reporting (Mutia D. & Dhamanti I., 2023)

Reporting culture reflects that healthcare workers have awareness, openness, and the courage to report every incident and potential incident related to patient safety as part of learning and improving service quality. The research findings indicate that the reporting-commitment culture is consistent with the respondents' characteristics: most respondents are women, who have worked longer due to their higher level of education and have attended patient safety training (Fadhillah, H. et al, 2018). The reporting culture at FKTP in East Java is categorized as *good* at 88.70% and *fair* at 11.29%. The assessment results of the IKP reporting culture in FKTP show that there are no longer any facilities with a *poor* reporting culture, because the mean score is 86.17, which falls under the *good* category. However, with a standard deviation of 9.772, there are still several FKTP facilities whose reporting culture is classified as *fair*.

A good reporting culture is characterized by a work environment that supports open communication, does not blame individuals (non-punitive culture), leadership support, and a reporting system that is easily accessible and understood by healthcare workers. Reporting is carried out without fear and is regarded as part of professional responsibility. (Evie Sulahyuningsih, D. T., 2017). "A good reporting culture is not oriented toward punishing individuals, but rather focuses on: system evaluation, identification of root causes, and preventing the recurrence of incidents. Errors are viewed as opportunities for organizational learning. Staff feel safe to express their opinions and to report incidents.. (Karmila, Suharni, & Alwi, M. K., 2023).

The analysis shows a strong and statistically significant positive relationship between the IKP reporting culture and the implementation of the six SKP ($\rho = 0.745$; $p < 0.001$; $n = 62$). The better the reporting culture for IKD/KNC, the better the implementation of the six SKP. Respondents have carried out the standard elements of accreditation assessment as a work culture aimed at improving service quality at FKTP. Each incident report serves as a basis for evaluation, root cause analysis, procedural improvements, and the enhancement of service quality. Organizations learn from incidents to prevent similar occurrences. Primary healthcare facilities (FKTP) with a strong reporting culture

generally demonstrate more effective team communication, optimal implementation of patient safety measures, improved adherence to the Six Patient Safety Goals (6 SKP), and superior service quality. Indicators of an incident/near-miss reporting culture include the frequency of incident reporting, open communication, non-punitive responses to errors, leadership support, feedback on reports, and organizational learning. (Hadi, I., 2017)

The better these indicators are, the stronger the patient safety culture within the healthcare organization. A study at Ben Mari Hospital Malang showed a significant relationship between patient safety culture and the behavior of reporting patient safety incidents ($p < 0.001$) (Valentin, Y. I. S., Firdaus, A. D., & Harningtyas, S., 2025). Based on Tri Yuli Kustini's research published in the *Journal of Management Nursing*, there is an influence of nurses' knowledge of patient safety culture on the reporting of patient safety incidents at RSUD ($p = 0.001 < 0.05$). (KPPRS, 2019). Anggraeni, D., Ahsan, and Azzuhri (2016) showed that patient safety culture has a significant effect on nurses' attitudes toward reporting patient safety incidents. (Dewi Anggraeni, A. M., 2016) Fadilah, C. (2019) reported that an incident reporting culture is one of the important dimensions of patient safety culture and can influence the implementation of patient safety goals. (Fadilah, C, 2019) Goolsarran et al. (2018) found that team-based learning and interprofessional simulation improve patient safety knowledge, team communication, and interprofessional collaboration. (Goolsarran, N. et.al, 2018; Kusumawati, A. S., 2018). According to Ismainar (2015), patient safety is a system aimed at making patient care safer through risk identification, incident reporting and analysis, learning from incidents, and implementing solutions to prevent injuries caused by errors or negligence in healthcare services. (Ismainar, H, 2015) (Heriyati, M. F.-H., 2019) Kusumawati (2018) found a significant relationship between patient safety culture and nurses' attitudes toward reporting patient safety incidents ($p = 0.005$). (Kustini, T. Y., 2024)

CONCLUSION

The assessment results of the reporting culture of IKP at accredited FKTP in East Java show that there are no longer any facilities categorized as having a *poor* reporting culture. The mean score is 86.17, which falls under the *good* category. However, with a standard deviation of 9.772, there are still several FKTP facilities whose reporting culture is classified as *fair*. The assessment results of the implementation of the six SKP at FKTP show that there are no longer any facilities categorized as having a *poor* reporting culture. The mean score is 90.70, which falls under the *good* category. However, with a standard deviation of 8.342, there are still several FKTP facilities whose reporting culture is classified as *fair*. There is a strong and statistically significant positive relationship between the IKP reporting culture and the implementation of the six SKP in accredited FKTP in East Java ($\rho = 0.745$; $p < 0.001$).

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