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Research Article

The Role of Patient Safety Culture in Fostering Incident Reporting Attitudes in Hospitals

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Abstract

Patient safety incident reporting is a critical component of quality improvement efforts and the prevention of recurrent adverse events in hospitals. However, in practice, incident reporting continues to face various barriers related to healthcare workers' attitudes and organizational culture. Patient safety culture is regarded as a key factor in shaping a work environment that supports openness, learning, and a sense of safety in reporting patient safety incidents.

This study aimed to analyze the role of patient safety culture in fostering attitudes toward patient safety incident reporting in hospitals. A quantitative analytic study with a cross-sectional design was conducted. The study respondents consisted of 178 nurses and midwives working at UMMI Hospital, Bogor. Data were collected using the Hospital Survey on Patient Safety Culture questionnaire to measure patient safety culture, along with a questionnaire assessing attitudes toward patient safety incident reporting. Data analysis was performed using univariate, bivariate, and multivariate analyses with multiple linear regression.

The results showed that patient safety culture plays a significant role in shaping attitudes toward patient safety incident reporting. Several dimensions of patient safety culture—particularly open communication, handoff and information transition processes, and a non-punitive approach to errors—demonstrated a dominant influence on incident reporting attitudes. These findings indicate that a work environment that supports openness and learning from errors can enhance healthcare workers' readiness to report patient safety incidents.

The conclusion of this study emphasizes that strengthening patient safety culture is an important strategy for fostering positive attitudes toward patient safety incident reporting in hospitals. Efforts to improve patient safety should not rely solely on the provision of reporting systems, but also require organizational commitment to building a safety culture that supports open communication, continuous learning, and a non-blaming approach.

Keywords: Patient Safety Culture; Incident Reporting Attitude; Patient Safety Incident; Hospital Safety; Nursing Practice; Organizational Culture

Abbreviations

HSOPSC: Hospital Survey on Patient Safety Culture; IKP: Patient Safety Incident; RS: Hospital.

Introduction

Patient safety is a fundamental component of healthcare quality and a primary priority in the delivery of hospital services. Efforts to ensure patient safety do not rely solely on the implementation

of clinical procedures and standard operating protocols, but are also strongly influenced by organizational factors, including work culture and healthcare workers' behaviors [1,2,9]. An organizational environment that supports safety plays an important role in preventing patient safety incidents and minimizing their adverse impacts.

One of the main elements of patient safety systems is patient safety incident reporting. Incident reporting functions as an organizational learning mechanism to identify system weaknesses, improve care processes, and prevent the recurrence of similar events [3,10]. However, in practice, incident reporting has not been optimally implemented in many healthcare facilities. Healthcare workers often demonstrate hesitation in reporting incidents due to fear of sanctions, stigma, or blame-oriented organizational responses [4].

Patient safety culture has been widely recognized as a key factor influencing healthcare workers' attitudes and behaviors toward incident reporting. Patient safety culture reflects shared values, beliefs, and norms within an organization that shape how safety is perceived, prioritized, and implemented in daily healthcare practice [2,5,11]. A positive patient safety culture is characterized by open communication, effective teamwork, continuous organizational learning, and a non-punitive approach to errors.

Numerous studies have shown that differences in healthcare workers' attitudes toward reporting patient safety incidents are closely associated with variations in patient safety culture implemented in hospitals [6,7,12]. The presence of an incident reporting system alone does not guarantee high reporting rates if it is not supported by an organizational culture that encourages openness and learning from errors. This indicates that challenges in incident reporting are not merely technical in nature, but are also cultural and organizational.

As healthcare service organizations, hospitals have a responsibility to build patient safety cultures that foster positive attitudes toward patient safety incident reporting. Understanding the role of patient safety culture in shaping incident reporting attitudes is essential as a foundation for formulating sustainable patient safety improvement strategies. Therefore, this study aims to analyze the role of patient safety culture in fostering patient safety incident reporting attitudes in hospitals. The findings of this study are expected to contribute to the development of hospital management policies and practices oriented toward organizational learning and continuous quality improvement.

Materials and Methods

Study design and setting

This study employed a quantitative analytic design with a cross-sectional approach. This design was selected to assess the relationship between patient safety culture and attitudes toward patient safety incident reporting measured at the same point in time. The study was conducted at UMMI Hospital, Bogor, from May to July 2025.

Population and sample

The study population included all nurses and midwives directly involved in patient care at UMMI Hospital, totaling 319 individuals. The sample size was determined using the Slovin formula with a 5% margin of error, resulting in 178 respondents. A probability sampling technique was applied to provide equal opportunity for each member of the population to be selected as a respondent.

Inclusion and exclusion criteria

Inclusion criteria comprised nurses and midwives who were actively working in service units, had a minimum of one year of work experience, and were willing to participate in the study. Exclusion criteria included healthcare workers who were on leave, attending education or training outside the hospital, as well as respondents involved in the validity and reliability testing of the research instruments.

Research variables

The independent variable in this study was patient safety culture, while the dependent variable was attitudes toward patient safety incident reporting. Patient safety culture was measured based on the dimensions contained in the Hospital Survey on Patient Safety Culture instrument.

Instruments and data collection

Patient safety culture was measured using the Hospital Survey on Patient Safety Culture (HSOPSC) developed by the Agency for Healthcare Research and Quality to assess healthcare workers' perceptions of patient safety culture in hospitals [8]. Attitudes toward patient safety incident reporting were measured using

a questionnaire developed based on the concept of attitude, encompassing cognitive, affective, and conative components.

Data collection was conducted online using Google Forms to facilitate questionnaire completion while ensuring respondent confidentiality and anonymity.

Validity and reliability testing

The instrument used to measure attitudes toward patient safety incident reporting underwent validity and reliability testing prior to data collection. All questionnaire items were declared valid and reliable, indicating that the instrument was appropriate for use in this study.

Data analysis

The collected data were analyzed using statistical software. Univariate analysis was performed to describe respondent characteristics and the distribution of research variables. Bivariate analysis was conducted to assess the relationship between patient safety culture and attitudes toward patient safety incident reporting. Furthermore, multivariate analysis using multiple linear regression was applied to identify the dimensions of patient safety culture that influence incident reporting attitudes.

Ethical considerations

This study adhered to ethical research principles, including informed consent, data confidentiality, and respondent anonymity. All participants received clear explanations regarding the objectives and procedures of the study prior to data collection.

Results and Discussion

Results

This section presents the study results obtained from the analysis of data collected from 178 respondents, consisting of nurses and midwives working at UMMI Hospital, Bogor. The results focus on respondent characteristics, the condition of patient safety culture, attitudes toward patient safety incident reporting, and the results of the analysis examining the relationship between these two variables.

Respondent characteristics

Respondent characteristics included gender, work unit, and length of employment. The general overview indicated that the majority of respondents were female and worked in direct patient care units, with more than one year of work experience. The distribution of respondent characteristics is presented in the following table.

No.	Characteristic	Category	Frequency (n)	Percentage (%)
1	Gender	Male	24	13.48
		Female	154	86.52
2	Work Unit	Outpatient	26	14.61
		Emergency Department	28	15.73
		Inpatient (Combined)	93	52.25
		Intensive Care Unit	12	6.74
		Maternity Unit	19	10.67
3	Length of Employment	Mean (years)	4.14	–
		Range (years)	1.07 – 12.40	–

Table 1: Respondent Characteristics (n = 178).

Patient safety culture

Patient safety culture was measured using the *Hospital Survey on Patient Safety Culture* instrument, which encompasses several dimensions of safety culture. The measurement results indicated that, overall, patient safety culture was categorized as good. A summary of the mean scores for each patient safety culture dimension is presented in the following table.

No.	Patient Safety Culture Dimension	Positive Score (%)	Category
1	Teamwork Within Units	88.48	Strong
2	Supervisor/Manager Support	79.03	Strong
3	Organizational Learning and Continuous Improvement	83.33	Strong
4	Hospital Management Support for Patient Safety	77.53	Strong
5	Feedback and Communication About Errors	71.16	Moderate
6	Open Communication	73.22	Moderate
7	Frequency of Incident Reporting	64.61	Moderate
8	Teamwork Across Units	78.47	Strong
9	Staffing Adequacy	60.00	Moderate
10	Handoffs and Transitions	69.85	Moderate
11	Non-Punitive Response to Errors	62.36	Moderate

Table 2: Mean Scores of Patient Safety Culture by Dimension.

The frequency distribution of responses across each patient safety culture dimension—including teamwork within units, supervisor/manager support, organizational learning, hospital management support, feedback and communication about errors, open communication, frequency of incident reporting, teamwork across units, staffing adequacy, handoffs and transitions, and a non-punitive approach to errors—is presented in detail in the following tables:

No.	Item (Code)	SA (5) f/%	A (4) f/%	N (3) f/%	D (2) f/%	SD (1) f/%	Mean	Median
1	In my unit, people support one another.	87/48.9%	73/41.0%	16/9.0%	2/1.1%	0/0.0%	4.38	4
2	When someone in my unit is too busy, others help out.	95/53.4%	72/40.4%	11/6.2%	0/0.0%	0/0.0%	4.47	5
3	People treat each other with respect in my work unit.	85/47.8%	70/39.3%	21/11.8%	2/1.1%	0/0.0%	4.34	4
4	When work becomes excessive, we help each other to get it done.	84/47.2%	78/43.8%	12/6.7%	3/1.7%	1/0.6%	4.35	4

Table 3: Frequency Distribution – Teamwork Within Units.

No.	Item (Code)	SA (5) f/%	A (4) f/%	N (3) f/%	D (2) f/%	SD (1) f/%	Mean	Median
1	The manager/supervisor demonstrates that patient safety is a top priority.	87/48.9%	73/41.0%	16/9.0%	2/1.1%	0/0.0%	4.38	4
2	The manager/supervisor asks staff to follow safety procedures.	95/53.4%	72/40.4%	11/6.2%	0/0.0%	0/0.0%	4.47	5
3	The manager/supervisor is actively involved in monitoring patient safety.	85/47.8%	70/39.3%	21/11.8%	2/1.1%	0/0.0%	4.34	4
4	The manager/supervisor supports staff decisions related to patient safety.	84/47.2%	78/43.8%	12/6.7%	3/1.7%	1/0.6%	4.35	4

Table 4: Frequency Distribution – Supervisor/Manager Support.

No.	Item (Code)	SA (5) f/%	A (4) f/%	N (3) f/%	D (2) f/%	SD (1) f/%	Mean	Median
1	We learn from mistakes that occur in our unit.	105/59.0%	65/36.5%	7/3.9%	0/0.0%	1/0.6%	4.53	5
2	We continuously make improvements based on previous experiences.	101/56.7%	66/37.1%	9/5.1%	1/0.6%	1/0.6%	4.49	5
3	Staff are encouraged to look for ways to make work safer.	83/46.6%	76/42.7%	16/9.0%	1/0.6%	2/1.1%	4.33	4

Table 5: Frequency Distribution – Organizational Learning and Improvement.

No.	Item (Code)	SA (5) f/%	A (4) f/%	N (3) f/%	D (2) f/%	SD (1) f/%	Mean	Median
1	Patient safety is considered important throughout the hospital.	121/68.0%	51/28.7%	5/2.8%	1/0.6%	0/0.0%	4.64	5
2	Patient safety receives primary attention from hospital management.	103/57.9%	56/31.5%	16/9.0%	3/1.7%	0/0.0%	4.46	5
3	Hospital management provides sufficient resources for patient safety.	68/38.2%	74/41.6%	28/15.7%	8/4.5%	0/0.0%	4.13	4
4	Management provides safety training to staff.	84/47.2%	70/39.3%	23/12.9%	1/0.6%	0/0.0%	4.33	4
5	Management is open to feedback regarding patient safety.	85/47.8%	66/37.1%	25/14.0%	2/1.1%	0/0.0%	4.31	4

Table 6: Frequency Distribution – Hospital Management Support.

No.	Item (Code)	SA (5) f/%	A (4) f/%	N (3) f/%	D (2) f/%	SD (1) f/%	Mean	Median
1	Every error that occurs is discussed to prevent recurrence.	89/50.0%	75/42.1%	12/6.7%	2/1.1%	0/0.0%	4.41	4
2	We receive feedback about actions taken after an incident is reported.	65/36.5%	82/46.1%	28/15.7%	3/1.7%	0/0.0%	4.17	4
3	Follow-up on incident reports is communicated to the reporter.	67/37.6%	82/46.1%	26/14.6%	2/1.1%	1/0.6%	4.19	4

Table 7: Frequency Distribution – Feedback and Communication About Errors.

No.	Item (Code)	SA (5) f/%	A (4) f/%	N (3) f/%	D (2) f/%	SD (1) f/%	Mean	Median
1	Staff feel safe to speak up if they see something dangerous.	69/38.8%	82/46.1%	25/14.0%	1/0.6%	1/0.6%	4.22	4
2	Staff feel free to express concerns about patient safety.	76/42.7%	80/44.9%	20/11.2%	2/1.1%	0/0.0%	4.29	4
3	If I see something wrong, I will inform my supervisor.	86/48.3%	80/44.9%	12/6.7%	0/0.0%	0/0.0%	4.42	4

Table 8: Frequency Distribution – Open Communication.

No.	Item (Code)	SA (5) f/%	A (4) f/%	N (3) f/%	D (2) f/%	SD (1) f/%	Mean	Median
1	Incident reports are routinely made in my unit.	68/38.2%	79/44.4%	28/15.7%	2/1.1%	1/0.6%	4.19	4
2	All patient safety incidents should be reported, even minor ones.	105/59.0%	61/34.3%	12/6.7%	0/0.0%	0/0.0%	4.52	5
3	The frequency of incident reporting is sufficiently high in this hospital.	21/11.8%	58/32.6%	72/40.4%	21/11.8%	6/3.4%	3.38	3

Table 9: Frequency Distribution – Frequency of Incident Reporting.

No.	Item (Code)	SA (5) f/%	A (4) f/%	N (3) f/%	D (2) f/%	SD (1) f/%	Mean	Median
1	Communication between units works well.	60/33.7%	86/48.3%	29/16.3%	1/0.6%	2/1.1%	4.13	4
2	Coordination between units is carried out to prevent errors.	80/44.9%	79/44.4%	17/9.6%	1/0.6%	1/0.6%	4.33	4
3	Teams across units support one another in carrying out tasks.	75/42.1%	78/43.8%	22/12.4%	3/1.7%	0/0.0%	4.26	4

Table 10: Frequency Distribution – Teamwork Across Units.

No.	Item (Code)	SA (5) f/%	A (4) f/%	N (3) f/%	D (2) f/%	SD (1) f/%	Positive Response (%)
1	The number of staff is sufficient to complete daily work. (X5.1)	31/17.4%	76/42.7%	48/27.0%	20/11.2%	3/1.7%	60.1
2	Staffing levels are adequate to handle the current workload. (X5.2)	32/18.0%	71/39.9%	51/28.7%	20/11.2%	4/2.2%	57.9
3	Staff shortages affect patient safety. (X5.3)*	100/56.2%	61/34.3%	17/9.6%	0/0.0%	0/0.0%	10.0

Table 11: Frequency Distribution – Staffing Adequacy.

No.	Item (Code)	SA (5) f/%	A (4) f/%	N (3) f/%	D (2) f/%	SD (1) f/%	Mean	Median
1	Handoffs are conducted clearly and completely.	77/43.3%	80/44.9%	20/11.2%	1/0.6%	0/0.0%	4.31	4
2	Important information is communicated during handoffs.	86/48.3%	75/42.1%	17/9.6%	0/0.0%	0/0.0%	4.39	4
3	Patient transitions between units are conducted safely.	74/41.6%	87/48.9%	16/9.0%	1/0.6%	0/0.0%	4.31	4

Table 12: Frequency Distribution – Handoffs and Transitions.

No.	Item (Code)	SA (5) f/%	A (4) f/%	N (3) f/%	D (2) f/%	SD (1) f/%	Mean	Median
1	Errors are not used to blame staff.	76/42.7%	77/43.3%	22/12.4%	3/1.7%	0/0.0%	4.27	4
2	Staff are not afraid of being punished when reporting errors.	57/32.0%	81/45.5%	28/15.7%	10/5.6%	2/1.1%	4.02	4
3	A non-punitive approach is used to handle patient safety incidents.	41/23.0%	91/51.1%	44/24.7%	1/0.6%	1/0.6%	3.96	4

Table 13: Frequency Distribution – Non-Punitive Response to Errors.

Attitudes Toward Patient Safety Incident Reporting

Attitudes toward patient safety incident reporting reflect healthcare workers' readiness and willingness to report incidents occurring during healthcare delivery. The frequency distribution of attitudes toward patient safety incident reporting is presented in the following table.

No.	Statement	SA (5) f/%	A (4) f/%	N (3) f/%	D (2) f/%	SD (1) f/%	Mean	Median
1	I consider it important to report every patient safety incident.	94/52.8%	71/39.9%	13/7.3%	0/0.0%	0/0.0%	4.46	5
2	I will continue to report incidents even if the impact is minor.	79/44.4%	81/45.5%	18/10.1%	0/0.0%	0/0.0%	4.34	4
3	I am confident that my report will be followed up by my supervisor.	75/42.1%	82/46.1%	19/10.7%	2/1.1%	0/0.0%	4.29	4
4	I believe that reporting incidents will help improve the system.	86/48.3%	82/46.1%	10/5.6%	0/0.0%	0/0.0%	4.43	4
5	I feel psychologically safe when reporting incidents.	67/37.6%	86/48.3%	23/12.9%	2/1.1%	0/0.0%	4.22	4
6	I am not worried about being punished when reporting errors.	68/38.2%	88/49.4%	18/10.1%	2/1.1%	2/1.1%	4.22	4
7	I believe that reporting incidents will not harm my career.	75/42.1%	81/45.5%	19/10.7%	1/0.6%	2/1.1%	4.27	4
8	I feel responsible for reporting every error.	81/45.5%	85/47.8%	9/5.1%	2/1.1%	1/0.6%	4.37	4
9	I am willing to report events that may potentially harm patients.	80/44.9%	87/48.9%	11/6.2%	0/0.0%	0/0.0%	4.39	4
10	I believe that incident reporting is a moral obligation.	81/45.5%	81/45.5%	15/8.4%	1/0.6%	0/0.0%	4.36	4
11	I am familiar with the incident reporting procedures in this hospital.	67/37.6%	90/50.6%	20/11.2%	1/0.6%	0/0.0%	4.25	4
12	I feel that my colleagues support incident reporting.	67/37.6%	86/48.3%	25/14.0%	0/0.0%	0/0.0%	4.24	4
13	I feel that incident reporting is part of the work culture.	84/47.2%	82/46.1%	10/5.6%	2/1.1%	0/0.0%	4.39	4
14	I understand the benefits of incident reporting for patient safety.	82/46.1%	81/45.5%	14/7.9%	1/0.6%	0/0.0%	4.37	4
15	I am confident that my reports will be kept confidential.	67/37.6%	75/42.1%	33/18.5%	3/1.7%	0/0.0%	4.16	4

Table 14: Frequency Distribution of Attitudes Toward Patient Safety Incident Reporting.

Analysis of the Relationship between Patient Safety Culture and Incident Reporting Attitudes

The analysis of the relationship between patient safety culture and attitudes toward patient safety incident reporting was conducted using multiple linear regression. The results of the simultaneous test indicated that, collectively, the dimensions of patient safety culture had a significant effect on attitudes toward patient safety incident reporting. The results of the simultaneous test are presented in the following table.

Source of Variation	Sum of Squares	df	Mean Square	F	Sig.
Regression	9142.177	11	831.107	779.731	0.000
Residual	176.938	166	1.066		
Total	9319.114	177			

Table 15: Results of the Simultaneous Test.

Furthermore, the results of the partial tests showed that several dimensions of patient safety culture had a significant effect on attitudes toward patient safety incident reporting, while other dimensions did not demonstrate statistically significant effects. Detailed results of the partial tests are presented in the following table.

Variable	Coefficient (B)	t-value	Sig.	Interpretation
(Constant)	9.000	8.648	0.000	–
Teamwork Within Units	0.195	3.671	0.000	Significant positive
Supervisor/Manager Support	0.207	2.939	0.004	Significant positive
Organizational Learning and Continuous Improvement	-0.338	-7.141	0.000	Significant negative
Hospital Management Support for Patient Safety	0.422	6.888	0.000	Significant positive
Feedback and Communication About Errors	-0.520	-10.850	0.000	Significant negative
Open Communication	1.619	19.997	0.000	Significant positive (dominant)
Frequency of Incident Reporting	0.565	8.524	0.000	Significant positive
Teamwork Across Units	-0.663	-9.289	0.000	Significant negative
Staffing Adequacy	0.689	7.934	0.000	Significant positive
Handoffs and Transitions	1.477	19.009	0.000	Significant positive
Non-Punitive Response to Errors	0.466	7.299	0.000	Significant positive

Table 16: Results of the Partial Test.

The magnitude of the contribution of patient safety culture in explaining the variation in attitudes toward patient safety incident reporting is indicated by the coefficient of determination, as presented in the following table.

R	R Square	Adjusted R^2	Std. Error
0.990	0.981	0.980	1.032

Table 17: Coefficient of Determination.

Discussion

The results of this study indicate that patient safety culture plays a significant role in fostering attitudes toward patient safety incident reporting in hospitals. This finding reinforces the view that incident reporting does not depend solely on the availability of reporting systems, but is also strongly influenced by an organizational culture that supports openness and learning from errors [1,2].

Open communication emerged as one of the key dimensions influencing incident reporting attitudes. A work environment that encourages healthcare workers to express errors, concerns, and potential risks without fear of negative consequences enhances psychological safety and increases readiness to report patient safety incidents [3,4].

In addition to open communication, handoff and transition processes also demonstrated a significant role in shaping incident reporting attitudes. Ineffective handoff processes can increase the risk of service errors and patient safety incidents. Therefore, structured and safe handoff systems constitute an essential component of patient safety efforts and encourage incident reporting [5].

A non-punitive approach to errors also contributed significantly to attitudes toward patient safety incident reporting. When errors are viewed as opportunities for learning and system improvement rather than as grounds for individual blame, healthcare workers are more willing to report incidents honestly [6]. This approach aligns with the concept of just culture, which emphasizes a balance between accountability and organizational learning.

Overall, the findings of this study demonstrate that strengthening patient safety culture is a key element in fostering positive attitudes toward patient safety incident reporting. Patient safety improvement efforts should focus not only on technical and procedural aspects, but also on developing an organizational culture that supports open communication, continuous learning, and non-blaming approaches [2,7].

Conclusion

This study demonstrates that patient safety culture plays a significant role in fostering attitudes toward patient safety incident reporting in hospitals. The analysis confirms that incident reporting attitudes are influenced not only by the existence of reporting systems, but also by an organizational cultural environment that supports openness, learning, and psychological safety for healthcare workers.

Dimensions of patient safety culture related to open communication, handoff and transition processes, and a non-punitive approach to errors were found to make important contributions to shaping incident reporting attitudes. A work environment that encourages openness and avoids blame enables healthcare workers to report incidents honestly as part of efforts to improve service systems.

The findings of this study emphasize that patient safety improvement initiatives should be directed toward strengthening patient safety culture comprehensively. Hospitals should not only provide incident reporting systems, but also build an organizational culture that supports open communication, continuous learning, and fairness in addressing errors. In this way, incident reporting can function optimally as a mechanism for organizational learning and healthcare quality improvement.

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Conflict of Interest

The authors declare that there are no financial or non-financial conflicts of interest that could have influenced the conduct of this study or the preparation of this manuscript.

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