

The reporting of patient safety incidents by nurses in both outpatient and inpatient units of the hospital." at dr. M. Djamil Padang

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ABSTRACT

This research aims to provide insights to the management of Dr. M. Djamil Padang General Hospital regarding the factors contributing to the decrease in incident reports, enabling the determination of follow-up steps, including policies aligned with the Analysis of Patient Safety Incident Reporting (PSIR) at Dr. M. Djamil Padang General Hospital in 2022. *Method:* This study employed a mixed-methods approach that combines quantitative and qualitative methods using a sequential explanatory design. The study population consisted of nursing staff in selected service units through proportionate random sampling, with five individuals participating in the qualitative research. *Results:* The implementation of the reporting system at Dr. M. Djamil Padang General Hospital was neither efficient nor optimal. Although health professionals submitted incident reports manually or directly through the application, the number of patient safety incident reports in 2022 showed a significant decrease, totaling 1,882 incidents compared with the previous year's 8,421 incidents. Barriers to incident reporting include motivation and fear, whereas knowledge regarding incident types and reporting is generally good. *Conclusion:* Quantitative research results indicate that respondents' knowledge of patient safety incidents is relatively good, with over 50% answering questions related to patient safety incidents correctly. Qualitative research findings revealed obstacles contributing to the decline in patient safety incident reporting, including respondent motivation, workload, and fear.

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INTRODUCTION

Patient safety is acknowledged as a priority in health care services (Rees et al., 2015). Patient Safety Incidents (PSI) are an integral part of Patient Safety in hospitals, as they have the potential to result in preventable injuries. Reporting patient safety incidents helps hospitals identify and address issues and mitigate risks that may occur in patient care (Motsumi et al., 2020).

Dr. M. Djamil Padang General Hospital is a national referral hospital and vertical hospital in West Sumatra. According to Minister of Health Regulation No. 11 of 2017 on Patient Safety, all

healthcare facilities, including Dr. M. Djamil Padang General Hospital, are required to implement Patient Safety (Minister of Health Regulation No. 11 of 2017 Concerning Patient Safety, 2017). Based on the data obtained by the researcher, in 2021 (January–December), Dr. M. Djamil Padang General Hospital managed a total of 8,421 patient safety incident reports, averaging 702 reports per month. By contrast, in 2022 (January–November), there were 1,758 patient safety incident reports, with an average of 160 reports per month. The decrease was approximately 340%.

Patient safety incidents are unintended occurrences and conditions that result in or have the potential to cause preventable harm to patients (Minister of Health Regulation Number 11 of 2017 on Patient Safety) (Minister of Health Regulation No. 11 of 2017 Concerning Patient Safety, 2017). According to the Hospital Patient Safety Committee (KKPRS) in the Patient Safety Incident Reporting (PSIR) Guidelines for the year 2015, Patient Safety Incidents are events or situations that can lead to harm (illness, injury, disability, death, etc.) that should not have occurred (Guidelines for Reporting Patient Safety Incidents (IKP) Year 2015, 2015).

In 2018, the WHO introduced the Framework on Integrated People-Centred Health, which outlined the assessment of high-quality healthcare services based on the seven dimensions of healthcare quality. These dimensions include: 1) safety, which ensures that services avoid harm to the individuals targeted by the provided care; 2) effectiveness in delivering evidence-based healthcare to those in need; and 3) person-centeredness, providing care that responds to individual preferences, needs, and values. 4) Timeliness: reducing waiting times and avoiding delays that may be detrimental to both recipients and providers of care. 5) Efficiency, maximizing the benefits from available resources, and avoiding waste. 6) Equity: Providing services that do not vary in quality based on age, gender, race, ethnicity, geographic location, religion, socioeconomic status, language, or political affiliation, ensuring equal service provision. 7) Integration, delivering coordinated services across levels and providers, making healthcare services available throughout the patient's life journey (Continuity and Coordination of Care: A Practice Brief to Support Implementation of the WHO Framework on Integrated People-Centred Health Services, 2018).

The Patient Safety Incident Data at Dr. M. Djamil Padang General Hospital show a decrease in the number of reports from 2021 to 2022. In 2021 (January–December), Dr. M. Djamil Padang managed a total of 8,421 patient safety incident reports, averaging 702 reports per month. In 2022 (January–November), there were 1,758 patient safety incident reports, with an average of 160 reports per month. The decrease was approximately 340% (Quality Committee of Dr. M. Djamil Padang General Hospital, 2022).

The exact cause of this decrease in the number of incident reports is not yet known. This study aims to provide input to the environmental management of Dr. M. Djamil Padang General Hospital regarding the factors contributing to the decline in incident reports, enabling the determination of follow-up steps, including policies aligned with the analysis of patient safety incident reporting (PSIR) at Dr. M. Djamil Padang General Hospital in 2022.

The exact cause of this decrease in the number of incident reports is unknown. This study aims to provide input to the environmental management of Dr. M. Djamil Padang General Hospital regarding the factors contributing to the decline in incident reports, enabling the determination of follow-up steps, including policies aligned with the analysis of patient safety incident reporting (PSIR) at Dr. M. Djamil Padang General Hospital in 2022 (Sethi et al., 2019).

This research is expected to provide an overview of the structural and functional management of Dr. M. Djamil Padang General Hospital regarding the analysis of factors influencing patient safety incident reporting. Based on the background description above, we will conduct a study titled "Analysis of Patient Safety Incident Reporting (PSIR) Evaluation at Dr. M. Djamil Padang General Hospital in 2022." This research specifically focused on the environment of Dr. M. Djamil Padang General Hospital, with the research sample being representative of the service units.

RESEARCH METHOD

This research is a mixed-methods study, employing both quantitative and qualitative approaches and a sequential explanatory design. Was conducted at Dr. M. Djamil Padang General Hospital, with the study period taking place from August to December 2023.

The population in this study comprised nursing staff in each service unit. The quantitative research sample consists of nurses working in units that provide direct patient care at Dr. M. Djamil Padang General Hospital. The sampling technique used in this research was proportional random sampling, resulting in a quantitative research sample size of 100 nurses. The qualitative research sample consists of 5 nurses who provide patient care and have previously made incident reports. Qualitative research respondents were selected from units that routinely report Patient Safety Incidents (PSI), including: a) Head Nurse of the Surgical Inpatient Unit, b) Head Nurse of the Non-Surgical Inpatient Unit, c) Head Nurse of the Maternity and Pediatrics Unit, d) Head nurse of the Integrated Cardiac Center Unit, e) Head Nurse of the Morning Rounds Unit

Quantitative research is processed using SPSS, determining the frequency distribution of respondent characteristics, and then the frequency of respondents' knowledge levels related to patient safety incidents (Ayisa et al., 2021). Qualitative research is processed through in-depth interviews and a review of supporting documents related to the types of patient safety incidents reported, the form of reporting patient safety incidents, and factors influencing the decrease in reporting patient safety incidents.

RESULTS AND DISCUSSIONS

Quantitative research results

Respondents This study utilized a sample of 100 nurses distributed across various units at Dr. M. Djamil Padang General Hospital. The following are the characteristics of the respondents:

Table 1. Respondent characteristics

Variable	Category	Frequency	Mode/Mean
Gender	Male	20	Predominantly Female
	female	80	
Age	<30 years	14	Predominantly 30-40 Years Old
	>40 years	21	
	30-40 years	65	
Education	D3	45	Predominantly Bachelor's Degree
	S1	52	
	S2	3	
Length of Service	≤ 1 years	4	Mean 10 years
	2 - 10 years	50	
	11 - 20 years	38	
	> 20 years	8	

The results of the analysis of the respondent characteristics in this study reveal several relevant findings. First, the majority of respondents were female (80%), indicating the dominance of the female gender in the respondent population. Second, in terms of age, the 30-40 age group dominated, with 65% of respondents, followed by the age group over 40 years (21%); only 14% of respondents were under 30 years old. This indicates that the 30-40 age group was the largest age group in this study. Third, in terms of education, the bachelor's degree level (S1) dominates with 52% of respondents, while 45% have a Diploma-3 (D3) education level, and only 3% have a master's degree (S2) level. Fourth, about 50% of the respondents had work experience of between 2 and 10 years, with 38% having work experience of between 11 and 20 years. Only about 4% of respondents had less than 1 year of work experience, while about 8% had been working for more than 20 years. On average, the respondents' length of service was approximately 10 years.

In this section, the results of the analysis regarding the level of employee knowledge regarding Patient Safety Incidents at Dr. M. Djamil Padang General Hospital are discussed. The collected data provide an overview of the extent to which employees understand patient safety incidents in hospitals (Stansfeld et al., 2021). Relevant analysis results on this topic can be found in Table 4, which we further examine to understand the level of employee knowledge and potential areas that may require improvement in the context of patient safety at Dr. M. Djamil Padang General Hospital.

Table 2. Employees' knowledge level regarding patient safety incidents

No item	Question	Answer Response	Frequency Percentage %		
			Correct	Incorrect	Did not answer
1	Unexpected Incidents are	Patient safety incidents resulting in patient injuries	50	50	0
2	Every incident occurrence must be internally reported to the Quality Committee no later than	2 x 24 hours	44	56	0
3	At least two identifiers are required for verbal identification, namely	Full name & date of birth	98	2	0
4	Administering medication to patients is done based on the principle	6 Correct	80	20	0
5	Risk assessment for inpatients is conducted when	Patient admitted to inpatient care	99	1	0
6	The following is considered a sentinel event, except	Unexpected Incidents related to patient identification	45	55	0
7	Incidents with a blue grading require a simple investigation within	7 days	45	55	0
8	Who should report incidents, except	Staff who are aware of the incident	76	24	0
9	The risk level in the probability assessment falls into category 3 if	Possible (1-2 times per year)	32	68	0

Based on the table above, the level of respondents' knowledge of patient safety incidents was quite good. The question that received the highest score was about the assessment of the risk of falls in inpatients, with 99 percent of the respondents answering correctly. This indicates that respondents had an understanding of patient safety incidents, particularly in the fall risk category.

In this analysis, the results related to the perceptions of hospital staff regarding workload will be explained. These data provide insights into how hospital staff perceive the level of workload they experience in carrying out their duties (Buil et al., 2019). Below is the tabulation of the obtained data (Table 3).

Table 3. Workload perception in the hospital environment

Answer category	Frequency	Percentage
When the workload is high, management asks us to work quickly, even by taking shortcuts.	4	.0
Reporting patient safety incidents is an additional burden that adds to the workload.	0	.0
The current number of employees is sufficient to handle the existing workload.	4	4.0
At times, I become very busy with my work.	1	1
No matter how difficult the workload is in recording and reporting incidents, employees in our unit will bear it together.	8	8.0
	4	4.0

Table 3 illustrates several important aspects related to hospital workload. It was found that 64% of respondents felt that, although the workload in recording and reporting incidents may be challenging, employees in their unit will bear it together. Additionally, approximately 18% of the respondents felt that they had become very busy in their work at certain times. Meanwhile, 14% of the respondents believed that the current number of employees was sufficient to handle the existing workload. However, only 4% felt that when the workload was high, management asked them to work quickly, even by taking shortcuts. Furthermore, no respondent felt that reporting patient safety incidents was an additional burden added to the workload. These results provide a varied overview of employees' perceptions of workload in hospitals. While most respondents agreed to bear the challenging workload collectively, some also indicated a high level of busyness in their work.

Qualitative Research Results

Qualitative data were collected to strengthen the findings from the quantitative research and to understand the informants' emergency response plans. Qualitative data collection for this study was conducted through in-depth interviews and document reviews. In-depth interviews were conducted with head nurses in the surgical inpatient unit, maternity, and pediatrics unit, morning rounds inpatient unit/Class VIV, cardiac unit, and nonsurgical inpatient unit. Five informants were included in this qualitative study, and a total of 5 informants were obtained.

Table 4. Code of in-depth interview informants

No.	Code Informant	Gender	Education	Work unit	Position
1	R1	Female	Bachelor of Nursing	unit rawat inap bedah	Supervising Nurse
2	R2	Female	Bachelor of Nursing	Maternity and Pediatrics Unit Supervising Nurse	Supervising Nurse
3	R3	Female	Bachelor of Nursing	Ambun Pagi Unit/Class VIV Supervising Nurse	Supervising Nurse
4	R4	Female	Bachelor of Nursing	Cardiac Unit	Supervising Nurse
5	R5	Female	Bachelor of Nursing	Non-Surgical Inpatient Unit	Supervising Nurse

Information in in-depth interviews was conducted through random sampling, where informants were randomly selected, and efforts were made to obtain varied information from each informant.

From the interview results, further information about the forms of incidents that occurred was obtained from the respondents.

"KNC incidents are potentially harmful events that impact patients but are still potential, such as potholed roads or getting wet, which patients will later pass through" (R4).

"KPCS incidents are potentially harmful events that impact patients but are still potential, such as potholed roads or getting wet, which patients will later pass through" (R3).

Based on the research results, the forms of incident reporting reported by various units participating in the research are KNC, KTD, KPCS, KTC, and sentinel. These incident reports have also been submitted to hospital management.

Table 5. Triangulation matrix of incident reporting forms

In-Depth Interview	Questionnaire	Document	Review Conclusion
All respondents are aware of the forms of incident reporting, namely	Based on the survey results, more than 50% of the research respondents are knowledgeable about	The frequently reported forms of incidents in 2022 were KNC with a total of 897 occurrences, KTC amounted to 461 occurrences, KTD amounted to 214	a) Respondents are aware of the forms of patient safety

In-Depth Interview	Questionnaire	Document	Review Conclusion
KTD, KNC, KTC, KPCS, and sentinel.	the forms of incident reporting.	occurrences, KPCs amounted to 307, and sentinel amounted to 3 occurrences. Thus, the total number of patient safety incidents (IKP) in 2022 was 1882, compared to 8421 occurrences in the previous year.	incident reporting. b) Patient safety incident reporting decreased in 2022.

Implementation. The forms of incident reporting implementation are direct and via telephone in 2022, but in 2023, it has become application-based. As mentioned in the following interviews:

“Reporting from IPJT in 2022 was done directly”. (R4)

“Patient safety incident reporting in 2022 was directly written”. (R5)

“Incident reporting in 2022 was still manual”. (R1)

Via telephone:

“If reporting a patient safety incident via telephone, I have been to the Quality Committee, but was told to report it directly in writing on the provided patient safety incident form”. (R3)

Mobile/application-based:

“Incident reporting is routinely carried out by colleagues in the field. Sometimes, nurses in the field are lazy enough to report patient safety incidents because the incidents often recur. In the past, reporting was done directly on the patient safety incident form, now it is through the SIRANCAK system”. (R3)

Based on the research results, it is shown that incident reporting in 2022 was carried out directly or manually, but also occasionally via telephone.

Table 6. Triangulation matrix of incident reporting implementation

In-depth interview	Questionnaire	Document Review	Conclusion
Directly, manually, and via telephone		The form of incident reporting implementation at RSUP Dr. M. Djamil Padang in 2022 was manual, reported through patient safety incident forms, including IKP, KNC, KTC, KTD, and KPCS forms.	There were no obstacles in the implementation of patient safety incident reporting.

Providers in Incident Reporting Implementation Factors influencing personnel in the patient safety incident reporting system include motivation, fear, knowledge, and management support, as observed through interviews with the following respondents:

Motivation: “Our colleagues in the field rarely report patient safety incidents because they believe that reporting incidents does not bring rewards, so only a few report incidents. The remuneration system here is difficult to raise patient safety incident reports, but it is easy to decrease them. Therefore, there is a lack of motivation among staff to report incidents, which is a constraint on reporting incidents. As a result, incident reporting from the cardiac unit has decreased from year to year. It is challenging for us to coordinate investigations with other units” ... (R4)

Fear: “There were no obstacles in reporting in 2022, but since the introduction of the digital system or SIRANCAK, there have been issues. The wording in the reports was unclear when opened on mobile phones, making it difficult to read. The fear factor in reporting by colleagues in the field is not present, but the incidents often recur, so they are reluctant to report. If a patient safety incident is related to another unit, usually there is no feedback from that unit” ... (R3)

Knowledge: “It is crucial to enhance patient safety culture by improving routine reporting of patient safety incidents” ... (R1) “We are well aware of the importance of knowing the types of patient safety incidents to enhance the patient safety culture in the hospital” ... (R4)

Based on the research findings, it is evident that several factors can influence personnel in reporting patient safety incidents, including motivation, knowledge, fear, and management support. The significance of management support in incident reporting can enhance staff motivation in reporting incidents.

Table 7. Triangulation matrix of incident reporting forms

In-depth interview	Questionnaire	Document Review	Conclusion
<p>Workload</p> <p>Knowledge</p> <p>Almost all respondents had a high level of knowledge regarding the forms of Patient Safety Incident (IKP) reporting.</p>	<p>Workload is not an excuse for incident reporting because 64% of respondents answered, "No matter how difficult the workload is in recording and reporting incidents, our unit's employees will bear it together."</p>	<p>The commonly reported incident types in 2022 were KNC with a total of 897 occurrences, KTC with 461 occurrences, KTD with 214 occurrences, KPCs with 307 occurrences, and sentinel with 3 occurrences. Thus, the total number of Patient Safety Incidents (IKP) in 2022 was 1882 incidents, compared to 8421 incidents in the previous year.</p>	<p>a) Reporting IKP decreased in 2022.</p> <p>b) The still low motivation of respondents to report IKP is due to the lack of rewards from management.</p> <p>c) Respondents are afraid to report simple investigations related to other units.</p>
<p>Motivation</p> <p>The motivation of respondents to report Patient Safety Incidents (IKP) is still low because there is no reward from management.</p>	<p>50% of respondents already have good knowledge regarding the forms of Patient Safety Incident (IKP), types of IKP, and the implementation of IKP reporting.</p>		
<p>Fear</p> <p>Respondents do not have fear in reporting IKP, but they are afraid to follow up on simple investigations related to other units because other units find it difficult to accept that there is an incident in their unit.</p>			

Discussion

Types of Incident Reporting

Based on the results, it is evident that the forms of incident reporting include almost all respondents being aware of patient safety incident reporting forms, such as Unexpected Incidents (KTD), Near-Miss Events (KNC), Non-Injury Events (KTC), Potentially Significant Injury Events (KPCS), and sentinel events. There was a decrease in IKP reporting by 2022 compared to 2021, with a decrease of 90%.

This research is in line with a study conducted by Mr. R.A. (2021) on the evaluation of the implementation of the patient safety incident reporting system by healthcare professionals at Hasanuddin University Hospital, where the reported types of incidents by healthcare professionals include KTD, KNC, KPC, KTC, and Sentinel events (Junaid et al., 2023).

Government Regulation No. 11 of 2017 on PATIENT SAFETY outlines frequently reported forms of patient safety incidents. These include Incident Not Expected (KTD), which generally involves non-serious injuries resulting from an action (commission) or the failure to take necessary action (omission), unrelated to the patient's underlying disease or condition (Park et al., 2020). Near-Miss Incident (KNC): These involve actions (commission) or the failure to take necessary action (omission) that could harm the patient but do not result in serious injury. Factors contributing to this include luck (e.g., a patient receiving a known contraindicated drug without adverse reactions), prevention (administration of a potentially lethal drug is canceled by other staff before administration), and warning (a drug with a lethal overdose is given, detected early, and the antidote is administered). Potential Injury Incident (KPC): These are conditions with a significant potential risk of causing injury, although no incidents have occurred yet. Non-Injury Incident

(KTC): These involve incidents that have been exposed to the patient but do not result in injury. Sentinel: A KTD that leads to death or serious injury.

Implementation Forms of Patient Safety Incident Reporting

Based on the research findings, the form of patient safety incident reporting at Dr. M. Djamil Padang General Hospital in 2022 was done directly or manually, written on paper in the Patient Safety Incident Form that complies with the standards of Regulation No. 11 of 2017. Interviews with respondents revealed that incident reports in the hospital were created directly by the staff who first observed or were involved in the incident (Choi et al., 2016). The reporting process begins with the discovery of incidents. The personnel who found it created a report by writing it on the Patient Safety Incident form, which was then followed up by the head of the unit and submitted to the Quality Committee of Dr. M. Djamil Padang General Hospital. This report includes patient biodata and chronology of the incident.

Data collection and retrieval must be performed validly (accurate, complete, timely, and reliable) because the data are used to analyze problems, evaluate services, and compare service methods or systems. The data source used for reporting is considered accurate (reliable) if it aligns with the flow and chronology of an incident. The report is also considered complete because it contains the aspects that need to be reported and aligns with the incident report, even if it is not immediately created at the time of the incident.

This research is consistent with the study conducted by Mr. R.A. (2021) on the evaluation of the implementation of the patient safety incident reporting system by healthcare workers at Hasanuddin University Hospital, where the forms of patient safety incident reporting include direct reporting, via telephone, and through SISMADAK.

Based on the Patient Safety Incident Reporting Guidelines (IKP) Patient Safety Incident Report (2015), many methods are used to identify risks, one of which is to develop reporting and analysis systems. It can be ensured that the reporting system encourages everyone in the organisation to be aware of the dangers or potential hazards that may occur to patients. Reporting is also crucial for monitoring efforts to prevent errors, thereby encouraging further investigation (Kintu et al., 2021). Personnel are given socialization and training on the incident reporting system, starting with the purpose, objectives, and benefits of reporting, the reporting process, how to fill out incident report forms, when to report, the definitions used in the reporting system, and how to analyze reports.

Factors Influencing Healthcare Workers in Incident Reporting Implementation

Based on the quantitative research results, it was shown that the knowledge factor of respondents regarding patient safety incidents was > 50%. This means that the respondents were already aware of everything about the IKP. Meanwhile, the qualitative research results indicated that almost all respondents had a high level of knowledge about the forms of IKP reporting. The majority of respondents in this study had good knowledge of the importance of healthcare workers reporting patient safety incidents. Respondents' knowledge of patient safety can be related to behavior, attitudes, and patient safety practices, categorized as positive behavior. Respondents are willing to report patient safety incidents because of their self-awareness of not harming others, understanding the importance of patient safety, and reporting.

This research is not in line with the study by Harsul W, Syahrul S, Majid A (2018) on the implementation of patient safety incident reporting culture in a regional hospital in South Sulawesi Province. It states that the knowledge of healthcare workers in reporting patient safety incidents in the regional hospital of South Sulawesi Province remains low. Therefore, mentoring, and monitoring evaluations can enhance the motivation and knowledge level of nurses in reporting IKP.

Knowledge of healthcare workers in reporting patient safety incidents is crucial to enhancing patient safety in hospitals. Knowledge is an indicator that can emerge from within an

individual, formed by attitudes, thereby influencing the behavior that drives someone to achieve specific goals (Chen et al., 2016). The level of knowledge, age, and length of service can influence an individual's knowledge level.

The results indicate that respondents do not fear reporting IKP. However, they are afraid of conducting simple follow-up investigations related to other units, because other units find it difficult to accept that incidents have occurred in their units. An ideal reporting system is needed that not only avoids punishment but also maintains confidentiality, provides timely reports, is analyzed by experts, and is system-oriented (Ma & Li, 2022). The results of the reports should be utilized for learning, determining priority scales in problem solving, and monitoring evaluations of the success or failure of a program.

This is in line with research conducted by Dhamanti et al. (2019), who stated that fear is one of the obstacles implementing a patient safety culture most frequently expressed by healthcare workers. Healthcare workers often choose not to report incidents out of fear of being blamed or punished, thus preventing conflicts among colleagues (Lombongkae et al., 2023)(Pravitasari, 2024)(Agil et al., 2025).

The research results indicate that the motivation of healthcare workers to report patient safety incidents at Dr. M. Djamil Padang Hospital remains low. This could be attributed to the lack of rewards provided by hospital management (Tulasi et al., 2021)(Djohan et al., 2023). Their motivation for reporting is the improvement of future services and a sense of responsibility toward performance, but this is not adequately appreciated by management (Kharisma & Wibowo, 2019).

This study aligns with the research conducted by (Mukhlis et al., 2022) on the relationship between nurse knowledge and the supervisory function of head nurses and nurses' motivation to report patient safety incidents. The findings of this study showed a significant relationship between nurses' motivation to report patient safety incidents (Cho & Han, 2018). Nurses with high motivation tended to work more productively and demonstrated a strong desire to achieve the goals of the nursing service unit and the overall hospital. Nurses with high motivation are inclined to work more productively and have a strong desire to achieve the goals of the nursing service unit and the hospital as a whole (Specialists et al., 2019).

Motivation consists of three main elements: need, drive, and goal. Needs arise when there is an imbalance between what is possessed and what is expected, while drivers are mental forces directed toward goal achievement. Therefore, the drive to achieve goals is at the core of the concept of motivation.

CONCLUSION

The implementation of the reporting system at Dr. M. Djamil Padang General Hospital has not been running well and optimally, despite incidents being reported by healthcare personnel. Incident reporting is done manually using an application, and in 2022, there was a significant decrease in patient safety incident reporting, with only 1882 incidents compared to 8421 incidents in the previous year. Several factors hinder the incident reporting process, including a lack of management support, teamwork collaboration, motivation, and fear. However, knowledge of the types of incidents and reporting is relatively good. Feedback from simple investigation reports is often not processed because of difficulties in collaborating with other units, whereas root cause analysis (RCA) takes a long time to complete, exceeding 45 days. Document review results indicate that follow-ups with simple investigations in 2022 were conducted for 1853 incidents, whereas RCA was performed for 29 incidents. However, only 12 incidents from the RCA process were completed. Regular evaluations of the patient safety incident reporting system should be conducted to enable the hospital to continuously learn from incidents and implement improvements to enhance patient safety at Dr. M. Djamil Padang General Hospital.

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References

- Agil, N. M., Apriyanto, A., Haryanti, T., Saparwati, M., Pertiwi, W. E., Oktarina, N. D., Syaifudin, A., Mawardika, T., & Fatimah, N. A. (2025). *Buku Ajar Keselamatan Pasien dan Keselamatan Kesehatan Kerja*. PT. Sonpedia Publishing Indonesia.
- Ayisa, A., Getahun, Y., & Yesuf, N. (2021). Patient Safety Culture and Associated Factors Among Health-Care Providers in the University of Gondar Comprehensive Specialized Hospital, Northwest Ethiopia. *Drug, Healthcare and Patient Safety, Volume 13*, 141-150. <https://doi.org/10.2147/DHPS.S291012>
- Buil, I., Martínez, E., & Matute, J. (2019). Transformational leadership and employee performance: The role of identification, engagement and proactive personality. *International Journal of Hospitality Management, 77*(October 2017), 64-75. <https://doi.org/10.1016/j.ijhm.2018.06.014>
- Chen, Y. P., Lee, H. F., & Wong, T. T. (2016). Epileptic seizure in primary intracranial sarcoma: a case report and literature review. *Child's Nervous System, 32*(9), 1709-1714. <https://doi.org/10.1007/s00381-016-3174-3>
- Cho, H., & Han, K. (2018). Associations among nursing work environment and health-promoting behaviors of nurses and nursing performance quality: A multilevel modeling approach. *Journal of Nursing Scholarship, 50*(4), 403-410.
- Choi, S. H., Gu, J. H., & Kang, D. H. (2016). Analysis of traffic accident-related facial trauma. *Journal of Craniofacial Surgery, 27*(7). <https://doi.org/10.1097/SCS.0000000000002916>
- Djohan, M., Madjid, A., & Ahmad, H. (2023). Pengaruh Imbalan Intrinsik dan Ekstrinsik Terhadap Kepuasan Kerja Perawat di Rumah Sakit Sinar Kasih Toraja Kabupaten Tana Toraja. *Media Publikasi Promosi Kesehatan Indonesia (MPPKI), 6*(9), 1898-1906.
- Guidelines for Reporting Patient Safety Incidents (IKP) Year 2015, (2015).
- Junaid, M., Zhang, Q., Cao, M., & Luqman, A. (2023). Nexus between technology enabled supply chain dynamic capabilities, integration, resilience, and sustainable performance: An empirical examination of healthcare organizations. *Technological Forecasting and Social Change, 196*, 122828.
- Kharisma, B., & Wibowo, K. (2019). Consistency of Planning and Budgeting of Basic infrastructure in West Java Province. *Economics Development Analysis Journal, 8*(1), 65-80. <https://doi.org/10.15294/edaj.v8i1.28129>
- Kintu, T. M., Ssewanyana, A. M., Kyagambiddwa, T., Nampijja, P. M., Apio, P. K., Kitaka, J., & Kabakyenga, J. K. (2021). Exploring drivers and barriers to the utilization of community client-led ART delivery model in South-Western Uganda: patients' and health workers' experiences. *BMC Health Services Research, 21*(1), 1-14.
- Lombongkaehe, C. M. N., Kaunang, E. D., & Karamoy, H. (2023). Analisis Pelaporan Insiden Keselamatan Pasien di Unit Rawat Inap Siloam Hospitals, Manado, Indonesia. *Medical Scope Journal, 4*(2), 193-200.
- Ma, F., & Li, Y. (2022). Critical Thinking Ability and Performance in Argumentative Essays of the Education Major Students. *Theory and Practice in Language Studies, 12*(1). <https://doi.org/10.17507/tpls.1201.17>
- Minister of Health Regulation No. 11 of 2017 Concerning Patient Safety, (2017).
- Motsumi, M. J., Mashalla, Y., Sebegu, M., Ho-Foster, A., Motshome, P., Mokokwe, L., Mmalane, M., & Montshiwa, T. (2020). Developing a trauma registry in a middle-income country - Botswana. *African Journal of Emergency Medicine, 10*. <https://doi.org/10.1016/j.afjem.2020.06.011>
- Mukhlis, H., Al-Hawary, S., Linh, H. V., Ibraheem, S., Hani, I. R., & Adnan, S. (2022). Religious capital and job engagement among Malaysian Muslim nurses during the COVID-19 pandemic. *HTS Teologiese Studies/Theological Studies, 78*(1).
- Park, T. Y., Son, S., Lim, T. G., & Jeong, T. (2020). Hyperthermia associated with spinal radiculopathy as determined by digital infrared thermographic imaging. *Medicine, 99*(11). <https://doi.org/10.1097/MD.00000000000019483>
- Pravitasari, R. F. (2024). FAKTOR YANG BERHUBUNGAN DENGAN PENERAPAN BUDAYA KESELAMATAN PASIEN DI RSIA X. STIKES Yayasan RS Dr. Soetomo Surabaya.
- Quality Committee of Dr. M. Djamil Padang General Hospital. (2022). *Patient Safety Incident Report of the Quality Committee for the years 2021-2022*.

- Rees, P., Edwards, A., Panesar, S., Powell, C., Carter, B., Williams, H., Hibbert, P., Luff, D., Parry, G., Mayor, S., Avery, A., Sheikh, A., Donaldson, S. L., & Carson-Stevens, A. (2015). Safety Incidents in the Primary Care Office Setting. *PEDIATRICS*, *135*(6), 1027-1035. <https://doi.org/10.1542/peds.2014-3259>
- Sethi, V., Yadav, S., Agrawal, S., Sareen, N., Kathuria, N., Mishra, P., Kapoor, J., & Dureja, S. (2019). Incidence of Side-effects After Weekly Iron and Folic Acid Consumption Among School-going Indian Adolescents. *Indian Pediatrics*, *56*, 33-34.
- Specialists, W. C., Nurses, E., West, S., & Care, C. (2019). *Procedure: Monofilament Testing for Loss of Protective Sensation of Diabetic/Neuropathic Feet (Adults and Children)*. 1-5.
- Stansfeld, S., Clark, C., Smuk, M., Gallacher, J., & Babisch, W. (2021). Road traffic noise, noise sensitivity, noise annoyance, psychological and physical health and mortality. *Environmental Health: A Global Access Science Source*, *20*(1). <https://doi.org/10.1186/s12940-021-00720-3>
- Tulasi, M., Sinaga, M., & Kenjam, Y. (2021). Faktor yang berhubungan dengan kinerja perawat di rumah sakit umum daerah kefamenanu kabupaten timor tengah utara. *Media Kesehatan Masyarakat*, *3*(1), 90-98.
- Continuity and coordination of care: A practice brief to support implementation of the WHO Framework on integrated people-centred health services, (2018).