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Original Article

Factors Associated Nurses Reporting of Patient Safety Incidents in Inpatient Wards : A Cross-Sectional Study

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Abstract

Background: Reporting of Patient Safety Incidents (PSIs) is a critical element of patient safety programs, supporting quality improvement and the prevention of recurrent adverse events.

Objective: This study investigated factors associated with nurses' compliance with PSI reporting in a hospital environment

Methods: A quantitative cross-sectional design was employed from 5 to 30 January 2026 in the inpatient wards of Siti Hajar Islamic Hospital, Mataram. Sixty-nine nurses participated through total sampling. Independent variables included perceived knowledge, non-punitive culture, leadership support, and accessibility of the reporting system; the dependent variable was compliance with PSI reporting. Data collection utilized a structured Likert-scale questionnaire, and analysis was conducted using the Spearman Rank correlation test and exploratory multivariate logistic regression.

Result: Compliance with PSI reporting was generally low. Most participants exhibited insufficient perceived knowledge, identified the non-punitive culture as inadequate, and reported restricted accessibility to the reporting system. Both bivariate and multivariate analyses revealed no statistically significant associations between the independent variables and PSI reporting compliance (all $p > 0.05$). In multivariate analysis, non-punitive culture (OR = 2.046, p = 0.155) and leadership support (OR = 1.315, p = 0.587) showed positive but non-significant associations with reporting compliance.

Conclusion: Nevertheless, the findings indicate that organizational culture and leadership may be important targets for enhancing patient safety practices. Further research with larger sample sizes is recommended to validate these results.

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Keywords
Patient Safety; Nursing Management; Reporting Incident.

Background

Patient safety is a core dimension of healthcare quality and a global priority for health systems. Despite significant advances in healthcare delivery, avoidable harm continues to pose a major public health concern. The World Health Organization (WHO) estimates that millions of patients experience preventable adverse events annually, resulting in prolonged hospitalization, disability, or death. In response, the WHO Global Patient Safety Action Plan 2021–2030 designates patient safety as a strategic priority and urges healthcare organizations to implement robust systems that prevent harm and foster continuous quality improvement. Patient Safety Incident (PSI) reporting constitutes a critical element of patient safety systems, enabling organizations to identify risks, investigate contributing factors, and implement preventive strategies. Rather than attributing blame to individuals, incident reporting functions as an organizational learning tool, transforming adverse events and near misses into opportunities for system-level improvement. Accordingly, the WHO recommends that healthcare facilities establish confidential, user-friendly, and learning-oriented reporting systems to enhance patient safety and reduce preventable harm (1).

Despite the recognized importance of incident reporting, underreporting remains a significant challenge in healthcare systems. Evidence suggests that a considerable proportion of patient safety incidents are not formally reported due to healthcare professionals' concerns about blame, disciplinary action, legal consequences, or perceptions that reporting systems are time-consuming, ineffective, and lack constructive feedback. These barriers inhibit reporting behavior and diminish opportunities for organizational learning and continuous quality improvement. As a result, underreporting restricts the identification of latent system failures and undermines healthcare organizations' ability to prevent the recurrence of adverse events (2).

Research indicates that both individual and organizational factors influence nurses' willingness to report patient safety incidents. At the individual level, perceived knowledge of patient safety principles and incident reporting procedures can affect reporting behavior. Organizational factors such as a non-punitive culture, supportive leadership, effective communication, and accessible reporting systems consistently emerge as key determinants of reporting compliance. Hospitals that foster psychological safety, provide constructive feedback, and encourage learning from errors typically report higher rates of incident reporting than organizations with blame-oriented cultures (3).

Although factors influencing patient safety incident reporting have been examined in various countries, evidence from Indonesian hospitals remains limited, particularly concerning the combined effects of perceived knowledge, non-punitive culture,

leadership support, and reporting system accessibility on nurses' reporting compliance. Most existing studies have concentrated on tertiary or teaching hospitals, with limited data from regional hospitals. Siti Hajar Islamic Hospital, Mataram, a secondary healthcare facility serving a diverse patient population, requires an effective patient safety reporting system to support continuous quality improvement. Identifying the factors associated with nurses' reporting compliance in this context is essential for developing evidence-based strategies to strengthen patient safety culture and organizational learning.

This study aims to analyze the factors associated with nurses' compliance with Patient Safety Incident reporting in the inpatient wards of Siti Hajar Islamic Hospital, Mataram.

Methods

Research Design

A quantitative cross-sectional study

Sample/Participants

The study population consisted of all registered nurses working in the inpatient wards. A total of 69 nurses were recruited using a total sampling technique. Inclusion criteria were active nurses who had worked in the hospital for at least six months, whereas nurses who were on leave during the study period or who did not complete the questionnaire were excluded. The independent variables included perceived knowledge, non-punitive culture, leadership support, and accessibility of the reporting system, while the dependent variable was compliance with Patient Safety Incident reporting.

Data Collection

Study was conducted from 5 January to 30 January 2026 in the inpatient wards of Siti Hajar Islamic Hospital, Mataram, Indonesia.

Before the main survey, the questionnaire underwent pilot testing involving 30 nurses to evaluate its psychometric properties. Construct validity was assessed using the Corrected Item–Total Correlation (CITC) with a minimum acceptable value of 0.30. All questionnaire items demonstrated acceptable construct validity. Internal consistency reliability was assessed using Cronbach's alpha coefficient, yielding coefficients of 0.660 for perceived knowledge, 0.785 for non-punitive culture, 0.786 for leadership support, 0.726 for accessibility of the reporting system, and 0.450 for compliance with Patient Safety Incident reporting. These findings indicate acceptable internal consistency across most questionnaire domains, although the compliance domain showed relatively lower reliability and was therefore interpreted with caution. Guidance on questionnaire development and psychometric evaluation followed established recommendations for health measurement instruments(6).

Questionnaires were distributed directly by the researcher after obtaining permission from the hospital management. Prior to completing the questionnaire, all participants received information regarding the study objectives and procedures and provided written informed consent. Each questionnaire required approximately 10–15 minutes to complete.

Questionnaire

The questionnaire was developed based on the conceptual framework of the World Health Organization (WHO) Global Patient Safety Action Plan 2021-2030, the Hospital Survey on Patient Safety Culture (HSOPSC) Version 2.0 developed by the Agency for Healthcare Research and Quality (AHRQ), and previous empirical studies concerning patient safety incident reporting, safety culture, leadership support, and organizational learning. The instrument was specifically designed to measure factors associated with nurses' compliance with Patient Safety Incident reporting in the study setting(5).

The questionnaire consisted of 22 items distributed into five domains: perceived knowledge (5 items), non-punitive culture (5 items), leadership support (4 items), accessibility of the reporting system (4 items), and compliance with Patient Safety Incident reporting (4 items). All items were measured using a four-point Likert scale, ranging from 1 (strongly disagree), 2 (disagree), 3 (agree), to 4 (strongly agree). Representative items included "I understand the procedures for reporting patient safety incidents" (perceived knowledge), "Staff are not blamed when reporting patient safety incidents" (non-punitive culture), "Hospital leaders encourage staff to report patient safety incidents" (leadership support), "The incident reporting system is easy to access" (accessibility of the reporting system), and "I consistently report patient safety incidents according to hospital procedures" (reporting compliance). The total score for each construct was calculated by summing all item scores within the corresponding domain, with higher scores indicating more favorable perceptions or higher reporting compliance. The total scores were subsequently categorized as good or poor according to the predetermined cut-off value used in this study. (Please replace this sentence with the actual categorization method used, such as the median, mean, or another predefined cut-off.)

Data Analysis

Data were analyzed using IBM SPSS Statistics version 26.0. Descriptive statistics were used to summarize respondent characteristics and study variables. Bivariate analysis was performed using the Spearman Rank correlation test, and exploratory multivariate logistic regression was conducted to evaluate the independent association between the study variables and compliance with Patient Safety Incident reporting, controlling for potential confounding variables. Considering the relatively small sample size, the multivariate analysis should be interpreted as exploratory rather than confirmatory. Statistical significance was established at $p < 0.05$.

The total score for each variable was obtained by summing the responses to all items within the corresponding domain, with higher scores indicating more favorable perceptions or higher compliance with Patient Safety Incident (PSI) reporting. For descriptive analysis, total scores were categorized as "good" or "poor" using the mean score for each variable as the cut-off point. Respondents with scores greater than or equal to the mean were classified as having good perceived knowledge, a non-punitive culture,

leadership support, accessibility of the reporting system, or reporting compliance, whereas those with scores below the mean were classified as having poor levels of these.

Ethical Clearance

This study was approved by the Health Research Ethics Committee of Health Research Ethics Committee (KEPK), Siti Hajar Islamic Hospital Mataram, with ethical approval number 001/KEPK/RSI-SH/EC/XII/2025. All procedures were conducted in accordance with the ethical principles of the Declaration of Helsinki. Participation was voluntary, written informed consent was obtained from all participants prior to data collection, and the confidentiality and anonymity of respondents were strictly maintained throughout the study.

Result and Discussion

Demographic of Participants

Table 1. Characteristics of Nurse Respondents (n = 69)

Variable	Category	n	%
Age	22–30 years	51	73.9
	31–40 years	18	26.1
Gender	Male	43	62.3
	Female	26	37.7
Education	Diploma (D3)	31	44.9
	Bachelor + Professional	38	55.1
Length of Service	< 1 year	7	10.1
	1–5 years	43	62.3
	> 5 years	19	27.5
Employment Status	Permanent	52	75.4
	Contract	17	24.6
Patient Safety Training	Attended	45	65.2
	Not attended	24	34.8

A majority of respondents had attended patient safety training (65.2%), possessed a bachelor's degree with a professional qualification (55.1%), and had 1–5 years of work experience (62.3%). These characteristics have the potential to influence nurses' understanding and implementation of patient safety practices. However, because these demographic variables were not included as independent variables in the present study, their associations with Patient Safety Incident (PSI) reporting compliance were not statistically examined. Future research should investigate these relationships.

Distribution of Research Variables

Table 2. Distribution of Study Variables

Variable	Category	n	%
Knowledge	Good	30	43.5
	Poor	39	56.5
Non-punitive Culture	Good	30	43.5
	Poor	39	56.5
Leadership Support	Good	38	55.1
	Poor	31	44.9
Accessibility of Reporting System	Good	27	39.1
	Poor	42	60.9
PSI Reporting Compliance	Good	32	46.4
	Poor	37	53.6

More than half of the respondents demonstrated poor perceived knowledge (56.5%), poor perceptions of a non-punitive culture (56.5%), inadequate accessibility of the reporting system (60.9%), and poor compliance with PSI reporting (53.6%). These findings indicate that barriers to incident reporting remain prevalent within the organization. From a hospital management perspective, these results suggest the need to strengthen patient safety education, promote a non-punitive reporting culture, improve the accessibility and usability of reporting systems, and establish effective feedback mechanisms to encourage reporting behavior.

Bivariate Analysis

Table 3. Association Between Factors and PSI Reporting Compliance (Spearman Rank Correlation)

Independent Variable	r	p-value
Knowledge	0.054	0.657
Non-punitive Culture	0.145	0.236
Leadership Support	0.153	0.210
Accessibility of Reporting System	−0.105	0.392

Spearman Rank correlation analysis found very weak correlations between all independent variables and PSI reporting compliance. Knowledge had a negligible positive correlation ($r = 0.054$, $p = 0.657$). Non-punitive culture ($r = 0.145$, $p = 0.236$) and leadership support ($r = 0.153$, $p = 0.210$) also showed very weak positive correlations. Accessibility of the reporting system showed a very weak negative correlation ($r = –0.105$, $p = 0.392$). None of these associations were statistically significant ($p > 0.05$), suggesting that these variables accounted for little of the variation in PSI reporting compliance.

Multivariate Analysis

Table 4. Factors Influencing PSI Reporting Compliance (Logistic Regression Analysis)

Variable	OR	95% CI	p
Knowledge	0.928	0.35–2.49	0.882
Non-punitive culture	2.046	0.76–5.49	0.155
Leadership support	1.315	0.49–3.54	0.587
Accessibility	1.257	0.46–3.46	0.657

DISCUSSION

Exploratory multivariate logistic regression analysis demonstrated that none of the independent variables were significantly associated with PSI reporting compliance. Nurses who perceived a good non-punitive culture were more likely to comply with PSI reporting than those with poor perceptions (OR = 2.046; 95% CI: 0.76–5.49; p = 0.155), although this association was not statistically significant. Similarly, leadership support (OR = 1.315; 95% CI: 0.49–3.54; p = 0.587), accessibility of the reporting system (OR = 1.257; 95% CI: 0.46–3.46; p = 0.657), and perceived knowledge (OR = 0.928; 95% CI: 0.35–2.49; p = 0.882) were not significantly associated with reporting compliance. The wide confidence intervals indicate considerable uncertainty around the estimated effects, which is likely attributable to the relatively small sample size.

This study examined the associations between perceived knowledge, non-punitive culture, leadership support, and the accessibility of the reporting system and nurses' compliance with reporting Patient Safety Incidents (PSIs) in inpatient wards. The findings demonstrated that none of the investigated variables were statistically associated with PSI reporting compliance in either the bivariate or exploratory multivariate analyses. Furthermore, although non-punitive culture exhibited the largest odds ratio (OR = 2.046), the association was not statistically significant, indicating that this finding should be interpreted with caution rather than as evidence of an independent effect, particularly considering the relatively small sample size and the wide uncertainty surrounding the estimated effect (7).

The absence of statistically significant associations observed in this study suggests that PSI reporting behavior is a complex, multidimensional process unlikely to be explained by a single organizational or individual factor. Instead, reporting compliance appears to emerge from the interaction among organizational culture, psychological safety, leadership practices, workload, reporting climate, individual motivation, and organizational learning processes rather than from isolated determinants (8)(9).

This interpretation is consistent with recent evidence demonstrating that incident reporting behaviour is shaped by multiple contextual and behavioural factors operating simultaneously(10) (11). A systematic review by Mahmoud et al. reported that barriers to patient safety learning systems commonly involve interactions between organizational culture, leadership commitment, communication, feedback mechanisms, and healthcare professionals' perceptions of psychological safety rather than deficiencies in a single organizational domain (12). Similarly, Dhamanti et al. found that under-reporting of

patient safety incidents in Indonesian hospitals was primarily attributed to organizational barriers, including fear of blame, insufficient managerial support, and a limited learning culture, rather than to individual knowledge alone (13).

Consequently, the findings of the present study should not be interpreted as evidence that perceived knowledge, non-punitive culture, leadership support, or reporting system accessibility are unimportant. Rather, the absence of statistically significant associations may reflect the complexity of PSI reporting behavior, the influence of additional determinants not measured in the present study, and the limited statistical power of the relatively small sample size. Similar interpretations have been proposed in recent patient safety literature, which emphasizes that non-significant findings in cross-sectional studies should be interpreted with caution because reporting behavior is influenced by dynamic organizational and contextual factors that may not be fully captured by a single survey conducted at a single point in time (3).

The majority of respondents in this study were young nurses aged 22–30 years, had 1–5 years of work experience, and had participated in patient safety training. Although these characteristics were not analyzed as independent variables, they may have influenced reporting behavior and partly explained the absence of statistically significant associations observed in this study. Nurses in the early stages of their careers generally possess adequate theoretical knowledge. However, they may have limited confidence in reporting patient safety incidents because they are still adapting to organizational norms, professional responsibilities, and communication patterns within clinical teams (14). Previous studies have shown that reporting behaviour is influenced not only by professional competence but also by clinical experience, psychological safety, and familiarity with organizational reporting procedures (15). Healthcare professionals with limited experience are more likely to perceive incident reporting as personally threatening, particularly in environments where reporting is associated with blame or negative performance evaluation(16).

Furthermore, although 65.2% of respondents had attended patient safety training, participation alone does not necessarily result in sustained reporting behavior. Contemporary evidence indicates that educational interventions are more effective when integrated with organizational feedback, leadership commitment, and opportunities to learn from reported incidents. In the absence of these supporting mechanisms, improvements in knowledge may not translate into behavioral change because healthcare professionals may perceive that reporting offers limited benefit or fails to lead to meaningful organizational improvement. Therefore, respondent characteristics should be interpreted as contextual factors that may interact with organizational culture and reporting climate rather than as direct determinants of PSI reporting compliance (17).

The present study found that perceived knowledge was not significantly associated with nurses' compliance in reporting Patient Safety Incidents. This finding suggests that knowledge of reporting procedures may be necessary but not sufficient to promote actual reporting behavior (18). Reporting patient safety incidents requires not only cognitive understanding but also confidence, organizational trust, psychological safety, and the

belief that submitted reports will be managed fairly and used to improve the system. Consequently, healthcare professionals may understand when and how incidents should be reported but still choose not to do so because of perceived organizational barriers or concerns about potential personal consequences. Similar observations have been reported in recent systematic reviews, demonstrating that incident reporting behavior is shaped by multiple interacting organizational and behavioral factors rather than by knowledge alone (19).

An important finding of the present study was that perceived knowledge was not significantly associated with nurses' compliance with Patient Safety Incident (PSI) reporting, despite most respondents having previously participated in patient safety training. This finding suggests that higher perceived knowledge, which may partly reflect previous educational exposure, did not necessarily translate into greater compliance with incident reporting. One possible explanation is that knowledge alone may be insufficient to influence reporting behaviour when organizational and behavioural barriers remain unresolved. Recent evidence suggests that educational interventions primarily improve healthcare professionals' knowledge and awareness; however, their impact on reporting behaviour is often limited unless they are supported by a positive patient safety culture, effective leadership, constructive feedback mechanisms, and continuous organizational learning (18).

Mahmoud et al. reported that inadequate training, weak patient safety culture, insufficient managerial support, punitive responses, and the absence of effective feedback mechanisms were among the most frequently reported barriers to healthcare professionals' active participation in patient safety learning systems (12). Similarly, Dhamanti et al. found that hospital leaders in Indonesia perceived fear of blame, inadequate feedback, limited organizational commitment, and a weak reporting culture as major contributors to under-reporting despite the implementation of patient safety programmes (13).

These findings indicate that educational interventions should be integrated with continuous feedback, leadership engagement, organizational learning strategies, and the development of a psychologically safe environment in which healthcare professionals feel supported to report incidents without fear of negative consequences (20).

Among all independent variables, non-punitive culture demonstrated the largest odds ratio (OR = 2.046); however, this association did not reach statistical significance. This finding should therefore be interpreted with caution and not regarded as evidence of an independent effect, particularly given the relatively small sample size and the wide confidence interval surrounding the estimated odds ratio (7).

Nevertheless, the observed direction of the association remains clinically meaningful because it is consistent with contemporary patient safety literature, which identifies non-punitive responses to errors as a fundamental component of patient safety culture and an important prerequisite for effective incident reporting and organizational learning(21). Healthcare professionals are more likely to report incidents when they perceive that reports will be used to facilitate organizational learning and system improvement rather than to impose individual punishment (12). Conversely, fear of blame, disciplinary

consequences, reputational concerns, and unsupportive managerial responses remain major barriers to incident reporting across diverse healthcare settings (22).

The lack of statistical significance observed in this study may be explained by several methodological and contextual factors rather than by the absence of a meaningful relationship. First, the relatively small sample size may have reduced the statistical power to detect moderate associations and contributed to imprecise effect estimates (7). Second, the relatively wide confidence interval indicates uncertainty regarding the magnitude of the observed association and therefore limits the precision of the estimated odds ratio (7). Third, perceptions of non-punitive culture were measured at the individual level. In contrast, patient safety culture is inherently an organizational construct that may differ across clinical units, leadership practices, and reporting systems (21). Consequently, individual perceptions may not fully reflect the broader organizational climate that shapes reporting behaviour (23). Similar findings have been reported in recent systematic reviews, which consistently demonstrate that incident reporting behavior is influenced by the interplay among leadership, communication, trust, learning culture, and feedback mechanisms rather than by isolated organizational factors (24).

Furthermore, recent evidence suggests that establishing a non-punitive culture requires considerably more than encouraging healthcare professionals to report incidents. Effective reporting systems require visible leadership commitment, timely feedback, confidential and user-friendly reporting processes, and tangible organizational improvements following incident analysis (25). When healthcare professionals perceive that submitted reports do not lead to meaningful organizational change, their motivation to report incidents may gradually decline, regardless of their perception of organizational culture (24). Therefore, strengthening a non-punitive culture should be integrated within broader patient safety learning systems that promote trust, transparency, organizational accountability, and continuous learning rather than focusing solely on eliminating blame (12).

Conclusion

This study found no statistically significant associations between perceived knowledge, non-punitive culture, leadership support, accessibility of the reporting system, and nurses' compliance with Patient Safety Incident (PSI) reporting in inpatient wards. These findings suggest that PSI reporting compliance is a complex behaviour that cannot be explained by individual or organizational factors in isolation. Instead, reporting compliance is likely influenced by the interaction of multiple organizational, behavioral, and contextual determinants that were not fully captured in the present study. Although none of the independent variables demonstrated a statistically significant association with PSI reporting compliance, these findings do not imply that the examined factors lack importance. The absence of statistical significance may be attributable to the relatively small sample size, limited statistical power, and the inherent complexity of incident-reporting behavior. Therefore, the exploratory logistic regression results, including the higher odds ratio observed for non-punitive culture, should be interpreted cautiously.

Practically, hospitals are encouraged to enhance patient safety programs by fostering a non-punitive reporting culture, supportive leadership, accessible reporting systems, effective feedback mechanisms, and ongoing organizational learning, as these strategies are consistently supported by the broader patient safety literature. Future research should involve larger, more diverse samples, employ longitudinal or interventional study designs, and incorporate additional organizational, behavioral, and psychological variables to provide a more comprehensive understanding of the factors influencing compliance with Patient Safety Incident reporting.

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Declaration of Conflict of Interest
None.

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Author Contributions
SR: Conceptualization, methodology, investigation, data collection, formal analysis, writing-original draft preparation. IH: Conceptualization, methodology, formal analysis, writing-review and editing, supervision. Z: Methodology, writing-review and editing, supervision. All authors have read and agreed to the published version of the manuscript.

Data Availability Statement
The dataset generated and analysed during the current study is available from the corresponding author upon reasonable request.

Declaration of the Use of AI in Scientific Writing
The authors declare that artificial intelligence (AI) tools were used solely to assist in language refinement and improving the clarity of the manuscript. The AI did not contribute to the study design, data analysis, or interpretation of results.

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