



From Blame Culture to Learning Culture in Healthcare Services (Literature Review)

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ABSTRACT

Patient safety is one of the key indicators of healthcare service quality. This study evaluates strategies for developing a safety culture in hospitals, focusing on shifting from a blame culture to a learning culture. The research employs Systematic Literature Review techniques. The findings indicate that management commitment, psychological safety, and staff engagement are critical components in fostering an effective safety culture. The study suggests the importance of continuous training and supportive reporting systems as strategies to enhance patient safety. This research contributes to a better understanding of how safety culture can be strengthened in hospital environments.

INTRODUCTION

In terms of global health services, patient safety has become one of the main indicators of the quality of medical services. Undesirable incidents in healthcare, especially those resulting in patient injury or even death, demonstrate the urgent need to strengthen safety culture in medical environments. The concept of patient safety culture, first widely introduced by the Institute of Medicine's *To Err is Human* report in 2000, focuses on establishing norms, values, and practices that prioritize patient safety above all else.

Patient safety culture can be defined as a set of values and norms shared by health workers that encourage openness and honesty in managing risks and errors that may occur in the health care process. This culture includes three main components: commitment from top management to safety, psychological safety that allows staff to report errors without fear of punishment, and active involvement of staff in safety improvement activities.

The importance of patient safety culture is not only limited to reducing medical errors, but also to improving the overall quality of healthcare services. Research has shown that hospitals with a strong safety culture have lower mortality rates, higher levels of patient satisfaction, and more efficient operational costs. Furthermore, a mature safety culture can improve staff morale, reduce job burnout, and increase staff retention.

One of the biggest challenges in implementing a safety culture is a paradigm shift from a culture that blames the individual to one that emphasizes continuous learning and improvement. In many cases, medical errors are viewed as personal failures that should be punished, rather than as opportunities for learning and system improvement. Other challenges include insufficient resources, resistance to change from medical staff accustomed to a certain way of working, and a lack of effective leadership in advocating and practicing safety principles.

Strategies to improve patient safety culture must be multifaceted and involve all levels of the organization. First, ongoing training and education must be provided to all healthcare staff about the importance of patient safety and practical ways to implement it in their daily routines. Second, the incident reporting system must be improved to make it easier to report and analyze errors that occur. Third, there must be changes in policies and procedures that promote psychological safety, so that staff feel safe to report misconduct without fear of retribution.

Several case studies from hospitals in various countries show that implementing effective patient safety strategies can reduce unwanted incidents significantly. For example, at one leading hospital in the United States, implementing a zero tolerance policy for patient misidentification resulted in a 70% reduction in the incidence of patient errors in one year. In Europe, a study in Swedish hospitals showed that improved communication between teams and regular training on patient safety could reduce the incidence of medical errors by up to 60%.

Patient safety culture is a critical component of effective and ethical health care management. Despite the challenges, changing the culture in the healthcare environment from one of blame to one of learning is essential to ensure patient safety. It requires commitment from all levels of the organization, from top management to field staff, to create a safe environment for patients and also for health workers themselves. Successfully implementing a safety culture will result in not only a reduction in undesirable medical incidents, but also an increase in operational efficiency and patient and staff satisfaction.

THEORETICAL REVIEW

Definition and Components of Patient Safety Culture

Patient safety culture is a concept that includes values, behaviors and norms shared by all members in a healthcare organization, with the aim of prioritizing patient safety above all other aspects. According to Weaver et al. (2013), patient safety culture is the result of a complex series of interactions between healthcare staff, the technology used, the work practices adopted, and the organizational environment. This emphasizes that safety culture is not just compliance with standards but is also an integral part of the work ethic of every individual in the health system.

One of the main components of a safety culture is top management commitment. Leotsakos et al. (2017) stated that without strong and continuous support from top management, efforts to develop and maintain a patient safety culture will face significant obstacles. Committed top management can be seen from the allocation of adequate resources, the creation of policies that support patient safety, and their presence in activities related to patient safety.

The second component is psychological safety. This concept, described by Edmondson (1999), refers to the ability of organizational members to be able to express opinions or report wrongdoing without fear of punishment or humiliation. Hospitals that have high psychological safety tend to have a better ability to handle incidents and learn lessons from any mistakes that occur.

Furthermore, active involvement of staff in safety improvement efforts is the third component. Sorra and Dyer (2010) show that staff who are actively involved in safety activities tend to be more motivated and have higher job satisfaction. This creates a positive circle where staff engagement improves the quality of patient safety, which in turn increases job satisfaction and further staff engagement.

Research conducted by Huang et al. (2024) showed that hospitals with a strong safety culture not only experienced a reduction in adverse medical incidents but also demonstrated increased patient and staff satisfaction. This confirms that the effective implementation of a patient safety culture contributes directly to improving the overall quality of health services.

The Importance of Safety Culture

The importance of safety culture in healthcare is a topic that continues to receive widespread attention among healthcare professionals and institutions. A strong safety culture is considered the backbone in improving the quality of

health services and reducing unwanted incidents, which can have fatal consequences for patients and harm institutions reputationally and financially. According to Weingart et al. (2013), hospitals with an effective safety culture tend to have lower rates of medical errors as well as increased job satisfaction among staff, which directly contributes to improving the quality of patient care.

Staff involvement at all levels is a vital component in establishing and maintaining an effective safety culture. Sorra and Dyer (2010) emphasize that empowering staff to actively participate in safety initiatives and decision making regarding safety policies can strengthen safety practices and increase transparency. This creates an environment where staff feel safe to report near misses and incidents without fear of retribution or punishment, which is a key aspect of what is called “psychological safety” in the patient safety literature.

Furthermore, implementation of evidence-based practices in patient safety, as recommended by the Institute of Medicine in its report entitled “To Err is Human” (2000), is essential to reduce errors and improve clinical outcomes. These practices include strict standard operating procedures, ongoing training, and the use of the latest technology for monitoring and evaluating care processes. The use of these evidence-based practices not only helps in reducing variability in the care provided but also establishes clear guidelines for safe and effective patient care.

On the other hand, developing a safety culture is also closely related to operational efficiency. As explained by March et al. (2021), hospitals with a mature safety culture are able to operate resources more efficiently, reduce waste, and improve coordination between teams, all of which contribute to reduced operational costs. This efficiency not only benefits hospitals from a financial perspective but also improves the accessibility and quality of services for patients.

Challenges in Implementation

Implementing patient safety culture in hospitals faces various complex and multidimensional challenges. One of the main challenges is the resistance to change that often arises from medical and non-medical staff. According to Weaver et al. (2013), this resistance may stem from long-standing habits that are ingrained in clinical and administrative practice. These habits are often considered safer or more efficient by staff, despite evidence to the contrary. Overcoming this resistance requires a comprehensive approach, including effective communication, training, and proving through data that changes will lead to improvements in quality of care.

Lack of resources is also a significant barrier to building and maintaining a culture of patient safety. According to Sorra and Dyer (2010), many hospitals face limitations in terms of financial and human resources needed to implement patient safety programs effectively. Investments in the latest technology, incident reporting systems and staff training are essential but often hampered by limited budgets. This requires top management to be very creative in allocating existing resources and seeking additional funding if necessary.

in advocating and implementing a safety culture. Leadership in patient safety is not just about top-level decision making, but also about the ability to influence and motivate staff at all levels. Research conducted by Huang et al. (2024) indicate that effective leadership in patient safety requires a deep understanding of risk factors in clinical practice and the ability to communicate with staff about the importance of following safety protocols.

On the other hand, a culture of blaming individuals when medical errors occur is one of the most difficult cultural barriers to change. The report "To Err is Human" by the Institute of Medicine emphasizes that medical errors should be seen as the result of system failure rather than individual failure. Moving the focus from blaming individuals to learning from each incident requires a paradigm shift at all levels of the organization. This includes adopting a systemic approach in analyzing incidents and applying learning from those incidents for continuous improvement.

Facing these challenges requires long-term commitment from all parties involved in the health system, from top management to field staff. With strong collaboration, communication and dedication, hospitals can overcome these challenges and build a strong, sustainable patient safety culture. Implementation of this strategy will not only reduce the incidence of medical errors but also increase patient and staff satisfaction, while demonstrating ethical and professional responsibility in healthcare practice.

Strategies to Improve Safety Culture

In improving the patient safety culture in a hospital, the strategy implemented must involve various aspects and levels of the organization, including continuing education, an effective incident reporting system, and policy changes that support the psychological safety of staff. The key to all of this is integration and collaboration between departments as well as the use of adequate technology to support these activities.

First, ongoing training and education is a strong foundation in building staff awareness and competency regarding patient safety. As described by Weaver et al. (2013), training programs should include safety simulations, workshops and ongoing learning sessions to ensure that staff understand current procedures and can apply them in real situations. This approach not only improves staff skills but also increases their awareness of the importance of patient safety activities.

Furthermore, the incident reporting system needs to be improved to ensure that every incident that occurs can be reported without fear of punishment, as emphasized by Sorra and Dyer (2010). This creates a safe environment where staff feel comfortable to share experiences and lessons learned from adverse events. Providing anonymous and responsive reporting channels, as well as systematic analysis of collected data, can help institutions understand certain patterns and make necessary improvements.

On the other hand, the importance of psychological safety in the work environment cannot be ignored. According to Edmondson (1999), psychological safety allows individuals to express themselves without fear of negative

consequences for themselves. In the case of hospitals, this means that staff must feel safe to talk about mistakes and learn from failures without shame or fear of retribution.

Technology integration is another important aspect of this strategy. Advanced information technology, such as electronic reporting systems and data analysis tools, can speed up the problem identification process and facilitate faster and more appropriate responses to safety incidents. This is explained in the study by Leotsakos et al. (2017), who showed that hospitals that integrate advanced technology in their safety systems tend to have lower rates of patient incidents.

By combining an evidence-based approach, technological support, and a supportive, open environment, hospitals can create an effective safety culture. These strategies must be continuously evaluated and adapted to ensure that they remain relevant to evolving safety challenges. Through a shared commitment between management and staff, as well as holistic and sustainable implementation of strategies, a strong patient safety culture is not only possible, but achievable.

How to Measure Patient Safety Culture

Patient safety culture is a crucial aspect in health services, with the aim of preventing unwanted events and providing safe and quality care. In measuring patient safety culture, it is necessary to use certain instruments such as the Hospital Survey on Patient Safety Culture (HSOPSC), Manchester Patient Safety Assessment Framework (MaPSaF), and Safety Attitudes Questionnaire (SAQ).

HSOPSC is a tool that helps in planning and evaluating patient safety programs. This instrument allows assessment at the individual, unit, or institutional level with 12 dimensions divided into three measurement areas. Meanwhile, MaPSaF helps reflect on the organization's aspect of developing a patient safety culture through 10 measurement dimensions and 24 aspects of implementing qualitative measurements. This instrument determines the maturity level of patient safety culture from pathological to generative.

SAQ, originally developed for the aviation industry, focuses on safety climate. This instrument asks teams within an organization to describe their attitudes toward the six dimensions of the SAQ. SAQ can be adapted to the conditions of each institution and health service unit, and used as an evaluation instrument after intervention.

Even though these three instruments were developed based on Reason theory, namely open culture, just culture, reporting culture, and learning culture, they each have their own advantages and disadvantages. The SAQ and HSOPSC are considered simple and practical measurement tools, with evidence demonstrating improved patient safety culture. Both are recommended based on previous research results.

METHODOLOGY

This research uses the Systematic Literature Review (TLR) technique. An extensive search was conducted of peer-reviewed articles, conference papers,

and other relevant studies from databases such as Scopus, Web of Science, and Google Scholar.

RESULTS AND DISCUSSION

The results of research by Andi Prafangesta at RSUD dr. Soediran Mangun Sumarso in 2023 shows that there is still large room for improvement in the implementation of patient safety culture. This research involved 228 health worker respondents and used the Hospital Survey on Patient Safety Culture (HSOPSC) instrument. The findings show that the level of communication openness is still in the medium category with a percentage of 65.4%. This indicates that despite efforts to support open communication, there are still barriers that prevent effective communication among staff. Existing literature suggests that institutions that score high in openness of communication tend to have lower safety incident rates and better compliance with safety protocols.

The research also found that the collaboration score within units was quite good (86.0%) but collaboration between units still needed to be improved (63.6%). This indicates the importance of effective teamwork to ensure continuity of care and reduce errors associated with patient handover. In addition, non-punitive responses to errors are still in the moderate category (75.4%), indicating that there are still concerns among staff about the negative consequences of reporting incidents. A non-punitive culture is key to encouraging incident reporting and learning from mistakes.

Further analysis shows that the overall perception of safety and frequency of incident reporting is also in the moderate category, with 43.8% of respondents admitting to not reporting an incident in the past 12 months. This suggests there are significant barriers to the reporting system which could be caused by a lack of trust in the system or fear of negative impacts from reporting.

Based on these results, it is recommended that hospitals increase efforts in educating and training staff about the importance of incident reporting and ensure that reporting is accepted as part of the learning process, not as a means of seeking scapegoats. Also, increasing cooperation between units can be done through simulations and joint exercises involving various units to improve coordination and team work efficiency.

Research by Guspianto, Ibnu Ismi, and Wardiah Rizalia at Ahmad Ripin Hospital, Muaro Jambi Regency in 2022 also revealed important findings regarding the implementation of patient safety culture. This study targets improving staff knowledge and attitudes towards patient safety culture through information dissemination and educational sessions. One of the key findings is that reporting of patient safety incidents has not been running optimally, indicating that there are obstacles to the openness and transparency that are essential in a patient safety culture.

The intervention carried out showed a significant increase in respondents' knowledge and attitudes towards the implementation of patient safety culture in hospitals, indicating the effectiveness of the educational

approach used in the research. These findings suggest that hospitals need to increase the capacity and ability of supervisors in implementing patient safety efforts at the unit and hospital level, including training and education aimed at motivating and encouraging staff to report any incidents that occur.

An article by Najihah N. from the Indonesian Muslim University in 2018 regarding patient safety culture and safety incidents in hospitals offers important insights into the correlation between safety culture and incidents that occur. This research confirms that a strong safety culture in a healthcare organization can minimize patient safety incidents, demonstrating a direct relationship between improving safety culture and decreasing patient safety incidents.

The study recommends several important steps for improvement, including improving reporting and learning from incidents, as well as strengthening management support for patient safety activities. This reflects the view of the literature linking strong executive support to better patient safety outcomes, suggesting that intervention strategies must be multifaceted and include training, leadership support, and efficient reporting systems to build and maintain an effective safety culture.

The research results presented by Huang et al. (2024) in the article *The Critical Role of Leadership in Patient Safety Culture: A Mediation Analysis of Management Influence on Safety Factors* also highlights the importance of management leadership in promoting patient safety culture in health organizations. This study, through a comprehensive mediation analysis of the Chinese version of the safety attitude questionnaire (CSAQ) and patient safety culture, explores how the interaction between these critical factors influences overall health outcomes.

From these findings, it is revealed that effective management leadership plays a key role in shaping safety attitudes and developing a resilient patient safety culture. Research shows that three critical aspects of patient safety – teamwork climate, working conditions, and recognition of stress – are completely mediated by management perceptions. This highlights the importance of management understanding and recognizing the impact of stress on patient safety and responding with policies and practices that promote a healthy and supportive work environment.

The mediation analysis conducted shows the importance of recognizing stress as a critical factor influencing organizational patient safety culture. This reflects the importance for management to understand and acknowledge how stress affects patient safety, and respond to it in a way that promotes a healthy work environment.

This research provides valuable insights for healthcare organizations looking to prioritize patient safety and improve overall quality of care. By enriching our understanding of the critical factors that shape safety attitudes and patient safety culture, this research offers guidance for management leadership to be effective and support a sustainable patient safety culture in healthcare organizations.

Research findings from Eka Setiawan and Rokiah Kusumapradja show that interprofessional collaboration, implementation of surgical safety checklists, and safety leadership have a positive and significant influence on patient safety culture. This study focuses on the influence of these variables in a central surgical setting, using safety leadership as a moderating variable in the relationship between interprofessional collaboration and implementation of a surgical safety checklist on patient safety culture.

This research found that effective interprofessional collaboration can improve patient safety culture. This shows that when healthcare teams from various disciplines work together effectively, patient safety can be improved. Good collaboration allows for better exchange of information and coordination of actions which is very important in the surgical setting.

Implementation of the surgical safety checklist has also been proven to improve patient safety culture. This checklist serves as an effective interprofessional communication tool, ensuring that all safety procedures are followed before, during, and after surgery. The effectiveness of this checklist in improving patient safety highlights the importance of standardized structures and procedures in clinical practice.

Additionally, safety leadership was found to not only directly improve patient safety culture but also play a moderating role that strengthens the relationship between surgical safety checklist implementation and patient safety culture. However, this study demonstrated that safety leadership did not successfully moderate the relationship between interprofessional collaboration and patient safety culture, suggesting that other factors may be more important when it comes to interprofessional collaboration.

This study provides empirical evidence that interprofessional collaboration, implementation of surgical safety checklists, and safety leadership are important determinants of patient safety culture. This suggests that healthcare leaders must understand that their role is not simply as supervisors but as an integral part of the team that promotes and supports an overall culture of patient safety.

Research described in Marchan, Shivaughn's (2023) article highlights the importance of healthcare staff's knowledge and perceptions of patient safety. This article examines the extent to which healthcare staff understand and apply patient safety principles and how their perceptions can influence safety practices in healthcare facilities.

The results showed significant variations in the level of knowledge about patient safety among healthcare staff. Staff with better knowledge of safety protocols and procedures tend to report higher levels of compliance with safety practices. This suggests that increasing education and training on patient safety can directly improve safety practices in hospitals.

In addition, the study also explored how healthcare staff's perceptions of patient safety influenced their behavior. It was found that positive perceptions of the work environment and patient safety policies were associated with increased incident reporting and involvement in safety initiatives. This suggests

that hospitals must work to build a supportive and open culture, where staff feel safe to report problems and contribute to improved safety.

The article "Knowledge and Perceptions of Patient Safety" provides important insight into how knowledge and perceptions can influence patient safety practices. Providing adequate education and building supportive perceptions among healthcare staff are key to improving patient safety. This research underscores the importance of a holistic approach to patient safety management that focuses not only on protocols, but also on human and organizational factors.

From the article by Jacobus, Dian & Setyaningsih, Yuliani & Arso, Septo (2022), it was found that factors such as leadership, communication and staff involvement play a crucial role in forming and maintaining a patient safety culture. This research found that effective leadership is critical in instilling a strong safety culture. Leaders who actively advocate and support safety practices tend to see higher levels of staff compliance with safety protocols.

Open and effective communication was also found to be essential in promoting patient safety. Staff who feel comfortable communicating their problems and concerns are more likely to be involved in improvement efforts. This suggests that hospitals must prioritize creating adequate and open communication channels.

Additionally, staff involvement is directly related to improved patient safety. Staff who are involved in decision making and improvement initiatives are more likely to adopt and maintain safety practices. This highlights the need for programs that encourage staff participation at all levels.

This article provides strong evidence that factors such as leadership, communication, and staff involvement play crucial roles in establishing and maintaining a patient safety culture. Addressing these factors in an integrated and systematic manner can help healthcare institutions not only meet patient safety standards but also exceed them, creating truly safe environments for patients and healthcare staff.

The article by Mutia, Davina & Dhamanti, Inge (2023) has examined how patient safety culture is measured and implemented in health care settings. This research focuses on identifying factors that influence patient safety culture and how these measurements can be used to improve safety practices.

In this study, various methodologies were used to measure patient safety culture, including surveys, interviews, and direct observation. Findings suggest that the combined use of these methods provides a broader and deeper understanding of how safety culture is implemented in daily practice and how staff respond to safety initiatives.

Analysis shows that several critical factors influence patient safety culture, including management commitment to safety, communication between teams, safety training and education, and incident reporting and response systems. Active involvement from leadership at all levels of the organization is necessary to support and strengthen an effective safety culture.

This research also found that accurate and regular measurement of patient safety culture can facilitate continuous improvement. By knowing areas

that need improvement, healthcare organizations can implement targeted changes that have the potential to reduce incidents and improve patient safety.

This research demonstrates the importance of effective and ongoing measurement of patient safety culture as a tool to drive and sustain improvements in clinical safety. By identifying and responding proactively to factors that influence safety culture, healthcare organizations can be more effective in minimizing risks and improving patient outcomes.

This article explores how various aspects of patient safety culture – such as a culture of openness, reporting, fairness, and learning – influence healthcare staff attitudes toward reporting patient safety incidents. This research was conducted at Mandaya Karawang Hospital and used a descriptive analytical approach with a cross-sectional method.

The research results show that a culture of openness and a culture of reporting do not have a significant influence on attitudes towards reporting patient safety incidents. This shows that the existence of open communication and formal reporting procedures alone is not enough to guarantee that staff will report incidents. This can be caused by other factors such as fear of consequences or lack of constructive feedback on the reports made.

In contrast, a culture of justice and a culture of learning show a very significant influence on attitudes towards reporting incidents. This emphasizes the importance of creating an environment where staff feel that mistakes and incidents are seen as opportunities to learn and not to assign blame. A culture of fairness that ensures that staff are not penalized for reported misconduct and a culture of learning that encourages continuous improvement are key to improving incident reporting.

This research underscores the importance of an organizational culture that supports and encourages reporting as a critical component of patient safety. While a culture of openness and reporting is a good first step, a culture of fairness and learning is most influential in promoting a proactive attitude toward patient safety. This conclusion supports efforts to improve patient safety that focus not only on structures and procedures, but also on building an organizational culture that supports safety as a priority.

Research conducted in Gamo zone, Southern Ethiopia, provides important insights into patient safety culture among nurses working in public hospitals. The results showed that only around 50.8% of study participants had the perception of a good patient safety culture. This study aims to assess patient safety culture and associated factors, providing important insights into the urgent need for intervention and improvement.

Factor analysis in this study identified several variables that have a significant influence on a good patient safety culture. Factors such as a bachelor's degree or higher education level, working in a surgical suite, lack of blame when medical errors occur, and weekly work hours of 40 to 49 hours are thought to contribute to better perceptions of security and safety procedures. These factors suggest that higher education and work specialization provide a better perception of security and safety procedures, while a blame-free work environment increases openness in reporting incidents.

This research highlights that only half of the nurses in Gamo zone public hospitals have the perception of a good patient safety culture. This indicates the need for concerted efforts from all parties involved in health care to improve patient safety standards. Continuously improving education and training, as well as creating a work environment that is supportive and free of blame is key to achieving this goal.

Mohammed et al. (2021) in their research entitled Patient safety culture and associated factors among health care professionals at public hospitals in Dessie town, north east Ethiopia, 2019 also highlighted the importance of patient safety culture in public hospitals. They found that only about half of the participants (44.8%) demonstrated a good patient safety culture, reflecting the challenges faced in strengthening awareness of the importance of patient safety among health workers. These results are in line with previous research which shows that awareness and implementation of patient safety is still low in developing countries.

This study also found that patient safety culture was positively associated with working in a primary care hospital, suggesting that institutional factors such as organizational size or type of health service may influence patient safety culture. Increasing awareness of the importance of patient safety at all levels of the hospital, especially at primary level hospitals, can be an important strategy to improve the overall patient safety culture.

However, there are several findings that indicate there are obstacles in building a good patient safety culture. For example, patient safety culture was negatively associated with healthcare professionals' age between 25-34 years and with working in pediatric and emergency departments. Further analysis is needed to understand the factors underlying this relationship, which may involve work experience, job stress, or the need for special training in patient safety.

In this case, views from experts in the field of risk management and patient safety may provide additional insight. Risk management experts may highlight the importance of implementing risk-oriented strategies to identify and reduce risk factors that may hinder patient safety culture. On the other hand, patient safety experts may emphasize the importance of a team-based approach and active involvement of staff in developing and maintaining a patient safety culture.

This research underscores the need for joint efforts from various parties, including hospital management, health workers, and regulators, to strengthen patient safety culture in public hospitals. Concrete steps, such as intensive training, promotion of awareness, and implementation of effective feedback systems, can help improve patient safety culture and, in turn, improve the overall quality of health care.

A comparative study conducted in Bahir Dar City, Northwest Ethiopia, entitled Job Satisfaction and Associated Factors among Health Professionals Working at Public and Private Hospitals: A Comparative Cross-Sectional Study, revealed that the level of job satisfaction among health professionals in public hospitals and the private sector is quite varied. Overall, the job satisfaction rate

was 55.2%, with significant differences between public and private hospitals. Job satisfaction in private hospitals is much higher (81.23%) compared to public hospitals (29.0%).

This research shows that the factors that contribute to job satisfaction between the two types of hospitals are also different. Health professionals working in private hospitals show a significant positive relationship with job satisfaction. This may be due to differences in work environment, recognition, and incentives between the two types of hospitals. The researchers also found that enjoyable work characteristics, autonomy, supportive supervision, good rewards and recognition, and high normative commitment also had a significant relationship with overall job satisfaction.

These findings are in line with previous research results showing that factors such as a positive work environment, autonomy, and recognition play an important role in increasing job satisfaction among health workers. For example, research conducted by Al-Hamdan et al. (2018) in Saudi Arabia found that support from superiors, career development, and professional recognition contributed significantly to nurses' job satisfaction.

However, the study also highlights the major challenges faced by health professionals working in public hospitals, with much lower levels of job satisfaction. This indicates the need for specific interventions focused on improving the work environment and working conditions in public hospitals, such as increasing supervisory support and providing fair incentives.

In health policy, these findings highlight the importance of developing evidence-based strategies to improve the job satisfaction of health professionals, especially in public hospitals. The policy should include efforts to improve the work environment, provide autonomy to staff, increase recognition and incentives, and strengthen organizational commitment. These steps will help increase retention of health staff critical to providing quality health services to the community.

The overall findings of these studies provide valuable insight into the challenges faced in improving patient safety culture and job satisfaction in healthcare settings in Ethiopia. Although much remains to be done, these findings provide a foundation for the development of more effective interventions in improving patient safety and job satisfaction in healthcare settings in Ethiopia and perhaps also in countries with similar situations.

Analysis conducted in the North Gondar Region, Ethiopia, by Dagnaw, Woreta, & Shiferaw (2018) showed that the utilization rate of good routine health information (RHI) among health professionals was 78.5%. This underlines that the majority of health workers in public health institutions in North Gondar make good use of health information. However, these findings need to be analyzed further to understand the factors that contribute to such high utilization rates.

A large body of health research shows that good use of routine health information is essential for planning, monitoring and evaluation in the health sector. However, this study shows that in Ethiopia, utilization of routine health

information is still low. Therefore, it is important to understand the factors that influence the level of routine health information utilization in the region.

One of the important findings of this study is that there is a significant relationship between gender and the level of use of routine health information. Research finds that female health professionals are more likely to make good use of routine health information compared to their male colleagues. This may be related to differences in information and knowledge behavior between the two groups.

In addition, the type of institution was also shown to be an important factor in the use of routine health information. Health professionals working in certain health institutions have a higher likelihood of making good use of routine health information. This may be due to differences in resources, organizational culture, and support available across health institutions.

In addition, this research also highlights the importance of standardized indicators, data analysis skills, and good governance in improving the use of routine health information. These factors can be considered as important pillars in ensuring that routine health information is not only generated, but also used effectively for better decision making at the health institutional level.

However, this study also has several weaknesses, including the use of a cross-sectional design that may not capture changes over time, as well as limitations in the generalizability of the findings due to the focus on a specific geographic area. Therefore, further research is needed to understand in depth the factors that influence routine health information utilization in Ethiopia and how these factors can be addressed to improve the effectiveness of the health system.

In this regard, intervention approaches that focus on improving data analysis skills, developing standardized indicators, and improving good governance in health institutions could be effective measures in increasing the utilization of routine health information in Ethiopia. Thus, this research makes an important contribution to the understanding of the challenges and opportunities in improving the effectiveness of health systems in developing countries.

Based on research results from Davina Satya Mutia and colleagues, published in the 2023 edition of the *Journal of Community Health*, measuring patient safety culture in primary health care is an important focus. This research was conducted in 242 primary health services in eight countries, using three main measurement instruments: SAQ-AV, MOSPSC, and HSOPSC. The results of the study revealed that there are several dimensions of patient safety culture that consistently receive low scores and require improvement.

Dimensions that often indicate a need for improvement include working conditions, work pressure and pace, and non-punitive responses to errors. These findings suggest that in primary health care, aspects such as management perception, working conditions, leadership support, frequency of incident reporting, staffing, and no-blame response all score low and require serious attention for improvement.

From an implementation perspective, this study highlights the importance of effective leadership and open communication in creating an environment that supports patient safety. Proactive leadership and a no-blame approach to dealing with errors are considered critical in establishing a positive safety culture.

This research also underscores the need for more intensive training for primary health staff to increase awareness and skills in implementing patient safety practices. This training is important to ensure that staff can recognize and reduce patient safety risks effectively.

The conclusion of this research is that to improve patient safety in primary health care, more focused and systematic efforts need to be made. Implementation of targeted strategies to improve low-scoring dimensions can help in ensuring the delivery of safe and quality health care. Thus, improving patient safety culture must be a priority for primary health care managers, with the support of adequate policies and sufficient resources to ensure patient safety.

Based on research results from Rokiah Kusumapradja and colleagues, published in Scientific Forum Volume 16 Number 3, September 2019, with the title "Patient Safety Culture in Teaching Hospitals," this research identifies various dimensions of patient safety culture in seven teaching hospitals in Indonesia. The research used a questionnaire survey with 1400 respondents providing patient care and patient safety quality committees, resulting in a response rate of 88%. Data analysis was carried out through path analysis.

The study results show that of the various dimensions measured, the staffing dimension has the lowest level of reliability, while Organizational learning—continuous improvement has the strongest level of reliability. Furthermore, in the implementation of the six patient safety goals, correctly identifying patients achieved the highest value, while improving effective communication had the lowest value. This research also found that patient safety culture had a significant effect on reducing adverse events.

Overall, these results emphasize the importance of strengthening certain dimensions of safety culture to optimize the implementation of patient safety goals, ultimately contributing to the reduction of adverse incidents. This research provides important insight into areas that require special attention in efforts to improve patient safety in teaching hospitals, especially in the context of effective staffing and communication.

Based on research results from Annisa Faradina Astini published in the Proceedings of SNaPP 2016 Health, this research explores the culture of patient safety at Stella Maris Hospital, Makassar. This study used a quantitative descriptive methodology with a sample of 136 respondents, using a patient safety culture questionnaire adapted from the Hospital Survey on Patient Safety Culture by AHRQ.

The results of this study show that the positive response rate towards patient safety culture at Stella Maris Hospital is 54.98%. The dimension with the highest positive response was collaboration within units, which reached

96.21%, indicating strong collaboration within certain units. In contrast, the inter-unit cooperation dimension received the lowest score with only 16.86%, indicating that there is still large room for improvement in coordination between departments or units.

Other dimensions such as management support for patient safety and shift changes and patient movement also scored low, indicating the need for more attention in managing patient safety at managerial and operational levels. Meanwhile, the dimensions of organizational learning and continuous improvement received a very high positive response, which shows that there are good efforts to apply learning from incidents that occur to improve safety processes and policies.

This research is important because it identifies areas that need strengthening in patient safety management and offers insight into how certain aspects of organizational culture can directly influence patient safety. The recommendation from this study is that hospitals should continue to increase efforts in low-scoring dimensions, especially in inter-unit collaboration and management support, to create a safer environment for patients.

Based on research results from Arum Astika and Arlina Dewi published in NASPUB, this study focuses on analyzing the maturity level of patient safety culture at PKU Muhammadiyah Hospital Yogyakarta. This research uses a mixed methods approach involving quantitative and qualitative methods to measure and describe patient safety culture using the MaPSaF (Manchester Patient Safety Framework) framework.

From the results of this research, PKU Muhammadiyah Yogyakarta Hospital shows that its overall patient safety culture is at a proactive level, with a score of 80%. This shows that the hospital is always alert to risks that may arise and is focused on efforts to anticipate patient safety problems by involving many stakeholders.

Furthermore, this research also reveals that there are several specific dimensions that are receiving more attention, including an overall commitment to continuous improvement, as well as the priority given to patient safety at a generative level. This shows that the hospital has made patient safety a top priority and a central mission in its operations.

However, this research also shows that there is still room for improvement, especially in terms of learning from incidents, incident evaluation, and communication and teamwork. Although PKU Muhammadiyah Yogyakarta Hospital has made many efforts to improve the patient safety system, improvements are still needed in several areas to reach an overall generative level.

This research is important because it provides insight into how a hospital in Indonesia implements and develops a patient safety culture. It also highlights the importance of involving multiple stakeholders in patient safety efforts and adopting a proactive approach to safety management. Furthermore, the findings from this research can be used as a basis for further research in developing and implementing patient safety strategies in other hospitals in Indonesia and throughout the world.

Based on research results from Wirasasmita Paripih and colleagues published in the *Suara Forikes Health Research Journal* Volume 14 Number 2, April 2023, this study aims to measure patient safety culture at the Muhammadiyah University Malang General Hospital using the HSOPSC survey. This research involved 138 respondents consisting of doctors, nurses and non-clinical employees.

The results showed that the overall average positive response rate for the 12 dimensions of patient safety culture was 71.4%. This indicates that in general, employees have a positive perception of the patient safety culture in their organization. The dimension with the highest positive response was "organizational learning - continuous improvement," while the dimension with the lowest response was "reporting and handover - exchange of information."

This research identified that although there is a generally positive perception of safety culture, there are specific areas that require further attention, particularly in relation to reporting and handover of information. The conclusion of this research is that there needs to be evaluation and improvement in the reporting and handover dimensions to increase the effectiveness of patient safety information exchange.

From this analysis, it is recommended that the management of the Muhammadiyah University of Malang General Hospital should focus on improving the reporting and handover process. This can include employee training, improving reporting systems to make it easier to report incidents, and strengthening communication between units. Implementation of health information technology, such as electronic Health Information Exchange (HIE), can also help facilitate better and more efficient information exchange between health workers.

Based on research results from Kinanthi Cahyaning Utami, Yanuar Jak, and Dicky Yulius Pangkey, published in the *Indonesian Journal of Hospital Management and Administration*, April 2023, this study investigates the influence of patient safety culture on attitudes towards reporting safety incidents at Mandaya Karawang Hospital. This research was conducted using a cross-sectional approach with data collected through questionnaires and other supporting data.

The research results show that the culture of justice and the culture of learning in hospitals have a significant influence on attitudes towards reporting patient safety incidents, with a significance value of 0.000 each. However, openness culture and reporting culture did not show a significant influence on this attitude, with significance values of 0.619 and 0.232 respectively.

Overall, the study results confirm that the presence of a culture of justice and a strong culture of learning in hospitals can increase staff's propensity to report safety incidents. This highlights the importance of strengthening these aspects in organizational culture to encourage more effective and open reporting practices, which in turn can improve overall patient safety

CONCLUSIONS AND RECOMMENDATIONS

From various studies conducted regarding patient safety culture in hospitals, it can be concluded that there is still significant room for improvement. Effective implementation of a safety culture shows a reduction in undesirable incidents and an increase in the overall quality of health services. The importance of effective leadership, open communication, and an environment that supports and does not punish staff who report incidents, are key factors in creating and maintaining a strong safety culture.

As a recommendation, hospitals need to develop and implement a comprehensive strategy that includes ongoing training and education for all health workers regarding the importance of patient safety and best practices in implementing it. Improving the incident reporting system is also highly recommended to make it easier for staff to report without fear of negative consequences. In addition, implementing simulations and joint exercises between units can improve coordination and teamwork efficiency, which in turn will strengthen the patient safety culture in the hospital.

With strong commitment from all levels of the organization, from top management to field staff, and effective and sustainable strategy implementation, hospitals can create a safer environment for patients and a more supportive work environment for health workers.

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REFERENCES

- (2024). Associations between patient safety culture and workplace safety culture in hospital settings. *BMC Health Services Research*. 24. 10.1186/s12913-024-10984-3.
- Andi, Prafangesta. (2023). Analisis Tingkat Kepuasan Pasien Terhadap Pelayanan Kefarmasian Di RSUD dr. Soediran Mangun Sumarso Wonogiri. *Journal of Islamic Pharmacy*. 7. 104-111. 10.18860/jip.v7i2.17693.
- Ayanaw, T., Worede, E. A., Alemayehu, M., Worku, W., Abere, G., & Betew, B. D. (2023). Patient safety culture and associated factors among health care providers in government and private hospitals, Bahir Dar City Northwest, Ethiopia, 2022: a comparative cross-sectional study. *BMC health services research*, 23(1), 765. <https://doi.org/10.1186/s12913-023-09770-4>
- Beyene Shashamo, B., Endashaw Yesera, G., Girma Abate, M., Estifanos Madebo, W., Ena Digesa, L., & Chonka Choramo, T. (2023). Patient safety culture and associated factors among nurses working at public hospitals in Gamo Zone, Southern Ethiopia. *BMC health services research*, 23(1), 670. <https://doi.org/10.1186/s12913-023-09671-6>
- Daba Wami, S. D., Demssie, A. F., Wassie, M. M., & Ahmed, A. N. (2016). Patient safety culture and associated factors: A quantitative and qualitative study of healthcare workers' view in Jimma zone Hospitals, Southwest Ethiopia. *BMC Health Services Research*, 16(1), 495. <https://doi.org/10.1186/s12913-016-1757-z>
- Dagnaw, E., Woreta, S. A., & Shiferaw, A. M. (2018). Routine health information utilization and associated factors among health care professionals working at public health institution in North Gondar, Northwest Ethiopia. *BMC health services research*, 18(1), 685. <https://doi.org/10.1186/s12913-018-3498-7>
- Edmondson, A. (1999). "Psychological safety and learning behavior in work teams." *Administrative Science Quarterly*, 44(2), 350-383.
- Geta, A., Biks, G. A., Dellie, E., & Yazachew, L. (2021). Job Satisfaction and Associated Factors among Health Professionals Working at Public and Private Hospitals in Bahir Dar City, Northwest Ethiopia: A Comparative Cross-Sectional Study. *BioMed research international*, 2021, 6632585. <https://doi.org/10.1155/2021/6632585>

- Guspianto, Guspianto & Ibnu, Ismi & Wardiah, Rizalia. (2022). PENINGKATAN BUDAYA KESELAMATAN PASIEN DI RSUD AHMAD RIPIN KABUPATEN MUARO JAMBI. *Medical Dedication (medic) : Jurnal Pengabdian kepada Masyarakat FKIK UNJA*. 5. 341-349. 10.22437/medicaldedication.v5i1.18642.
- Huang, Chih-Hsuan & Wu, Hsin-Hung & Lee, Yii-Ching & Li, Xiumei. (2024). The Critical Role of Leadership in Patient Safety Culture: A Mediation Analysis of Management Influence on Safety Factors. *Risk management and healthcare policy*. 17. 513-523. 10.2147/RMHP.S446651.
- Institute of Medicine (2000). "To Err Is Human: Building a Safer Health System." National Academy Press, Washington, D.C.
- Jacobus, Dian & Setyaningsih, Yuliani & Arso, Septo. (2022). ANALISIS PENGARUH BUDAYA KESELAMATAN PASIEN, BUDAYA ORGANISASI, DAN LINGKUNGAN YANG MENDUKUNG TERHADAP MOTIVASI MELAPORKAN INSIDEN KESELAMATAN PASIEN-SYSTEMATIC RIVIEW. *An-Nadaa Jurnal Kesehatan Masyarakat*. 9. 157. 10.31602/ann.v9i2.6842.
- Leotsakos, A., Zheng, H., & Sundt, T. (2017). Patient safety culture: lessons learned from the first decade. *Current Opinion in Anesthesiology*, 30(6), 748–756. <https://doi.org/10.1097/ACO.0000000000000521>
- March, J., et al. (2021). "Impact of Hospital Safety Culture on Patient Safety Outcomes: A Literature Review." *Journal of Healthcare Leadership*.
- Marchan, Shivaughn. (2023). PATIENT SAFETY AND PATIENT SAFETY CULTURE IN A DENTAL SCHOOL Knowledge and Perceptions of Patient Safety and Patient Safety Culture in a Dental School: A Qualitative Study. 10.13140/RG.2.2.22543.15527.
- Mohammed, F., Taddele, M., & Gualu, T. (2021). Patient safety culture and associated factors among health care professionals at public hospitals in Dessie town, north east Ethiopia, 2019. *PloS one*, 16(2), e0245966. <https://doi.org/10.1371/journal.pone.0245966>
- Mutia, Davina & Dhamanti, Inge. (2023). Pengukuran Budaya Keselamatan Pasien di Pelayanan Kesehatan Primer: Literature Review. *Jurnal Kesehatan Komunitas*. 9. 418-430. 10.25311/keskom.Vol9.Iss2.1343.
- Najihah, N. (2018). BUDAYA KESELAMATAN PASIEN DAN INSIDEN KESELAMATAN PASIEN DI RUMAH SAKIT: LITERATURE REVIEW. *Journal of Islamic Nursing*, 3(1), 1-8. <https://doi.org/10.24252/join.v3i1.5469>

- Setiawan, Eka & Kusumapradja, Rokiah. (2024). Determinants of Patient Safety Culture: The Role of Safety Leadership Interactions. *Jurnal Manajemen dan Organisasi*. 15. 97-112. 10.29244/jmo.v15i1.50690.
- Singh, H., Thomas, E. J., Petersen, L. A., Studdert, D. M., Dismukes, K., & Weingart, S. N. (2017). Medical errors involving trainees: A study of closed malpractice claims from 5 insurers. *Archives of Internal Medicine*, 167(19), 2030–2036. <https://doi.org/10.1001/archinte.167.19.2030>
- Sorra, J., & Dyer, N. (2010). Multilevel psychometric properties of the AHRQ hospital survey on patient safety culture. *BMC Health Services Research*, 10(1), 199. <https://doi.org/10.1186/1472-6963-10-199>
- Wami, S. D., Demssie, A. F., Wassie, M. M., & Ahmed, A. N. (2016). Patient safety culture and associated factors: A quantitative and qualitative study of healthcare workers' view in Jimma zone Hospitals, Southwest Ethiopia. *BMC health services research*, 16, 495. <https://doi.org/10.1186/s12913-016-1757-z>
- Weaver, S. J., Lubomksi, L. H., Wilson, R. F., Pfoh, E. R., Martinez, K. A., & Dy, S. M. (2013). Promoting a culture of safety as a patient safety strategy: A systematic review. *Annals of Internal Medicine*, 158(5), 369–374. <https://doi.org/10.7326/0003-4819-158-5-201303051-00002>
- Weingart, S. N., et al. (2013). "Hospital Patient Safety Culture: Relationships with Adverse Events and Disciplinary Action." *Medical Care Research and Review*.
- Wulan, Desi & Rosyidah, Rosyidah & Rulyandari, Rochana. (2024). Penerapan Budaya Keselamatan Pasien Di Rumah Sakit: Narrative Literature Review Implementation Of Patient Safety Culture In Hospitals: Narrative Literature Review. *Afiasi Jurnal Kesehatan Masyarakat*. 08. 527-539. 10.31943/afiasi.v8i3.
- Dhamanti, I. (2021, September 16). Instrumen Pengukuran Budaya Keselamatan Pasien. *Unair News*. <https://journal.umy.ac.id/index.php/mrs/article/view/11253>
- Mutia, D. S., Dhamanti, I. (2023). Pengukuran Budaya Keselamatan Pasien di Pelayanan Kesehatan Primer: Literature Review. *Jurnal Kesehatan Komunitas*, 9(2), 418-430. <https://doi.org/10.25311/keskom.Vol9.Iss2.1343>

- Kusumapradja, R., Rita, K., Maryanti, S., & Rumana, N. A. (2019). Budaya Keselamatan Pasien di Rumah Sakit Pendidikan. *Forum Ilmiah*, 16(3), 309-323.
- Astika, A., & Dewi, A. (2021). Analisis Tingkat Maturitas Budaya Keselamatan Pasien di Rumah Sakit Terakreditasi Paripurna (Studi Kasus di RS PKU Muhammadiyah Yogyakarta). NASPUB.
- Astini, A. F. (2016). Gambaran Budaya Keselamatan Pasien di RS Stella Maris Makassar. *Prosiding Seminar Nasional Penelitian dan PKM Kesehatan*, 6(1), 152-163.
- Paripih, W., Martiana, T., & Dhamanti, I. (2023). Mengukur Budaya Keselamatan Pasien di Rumah Sakit Umum Universitas Muhammadiyah Malang Menggunakan Survei HSOPSC. *Jurnal Penelitian Kesehatan Suara Forikes*, 14(2). <http://dx.doi.org/10.33846/sf142233>
- Utami, K. C., Jak, Y., & Pangkey, D. Y. (2023). Pengaruh Budaya Keselamatan Pasien Terhadap Sikap Melaporkan Insiden Keselamatan Pasien di Rumah Sakit Mandaya Karawang. *Jurnal Manajemen Dan Administrasi Rumah Sakit Indonesia (MARSI)*, 7(2). E-ISSN: 2865-6583, P-ISSN: 2868-6298.