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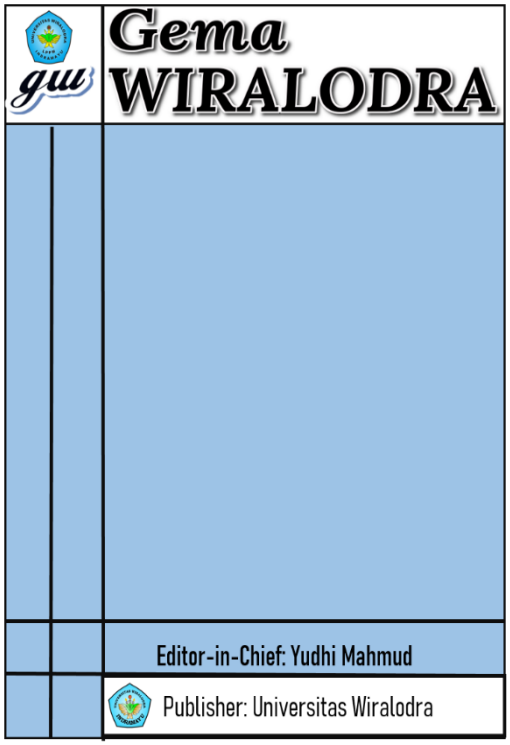

Description of Patient Safety Culture Based on AHRQ Method in Employees of St. Madyang Hospital, Palopo City

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Description of Patient Safety Culture Based on AHRQ Method in Employees of St. Madyang Hospital, Palopo City

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Abstract
Patient's safety is a primary concern as it has now emerged as an international challenge confronting the healthcare system in hospitals. The initial step in a hospital's patient safety initiative is to cultivate a culture of patient safety or to enhance awareness among all staff regarding the significance of safety values in hospitals. This study aims to describe patient safety based on AHRQ method in employees at St. Madyang Hospital, Palopo City. This research utilizes a *cross-sectional* study design, with a sample 107 employees. The sample was obtained using systematic random sampling technique. The research instrument used was a questionnaire based on AHRQ (2019) version 2.0 method from the side of hospital employees can be measured through 10 dimensions. Data analysis used was descriptive analysis. The results of the study showed a positive response of 68% or included in the category of Medium Safety Culture. The highest score (91%) was in the Communication About Errors dimension, while the lowest score (33%) was in the Number of Events Reported dimension. It is essential to encourage employees to report incidents consistently, as regular reporting can facilitate safer and more accessible reporting systems, ultimately promoting safety and helping to prevent accidents or injuries in the future.
Keywords: Patients Safety, Culture, AHRQ Methods, Hospital

1. Introduction

Patient safety is a primary concern as it has now emerged as an international challenge confronting the healthcare system in hospitals. Patient safety is intimately tied to the incidence of Patient Safety Incidents within hospitals. The initial step in a hospital's patient safety initiative is to cultivate a culture of patient safety or to enhance awareness among all staff regarding the significance of safety values in hospitals. (Wahyuda O et al., 2024) Since 2019, the World Health Organization (WHO) has promoted the importance of patient safety through the commemoration of World Patient Safety Day. The goal is for every individual to receive health services without experiencing injury. However, globally, data shows that every year there are around 134 million hospitalized patients in low- and middle-density countries who experience incidents related to hospital care. (Henik Saefulmilah & Prasetyo, 2024)

The many unpredictable events that occur at any time require patient safety to be an integral part of the culture in health facilities, with the hope of improving the quality of services provided. (Wahyuda O et al., 2024) Worldwide, around 10% of patients experience an unexpected event while being treated in a hospital, of which around half could actually be prevented. Of these unexpected events, around 7% end in death, while the other half can cause disability, either temporary or permanent. (Hesgrove et al., 2024) Therefore, hospitals should implement a patient safety culture to create safe, comfortable and quality health services for every patient. (Maesa et al., 2024)

As hospitals persistently aim to enhance patient safety and quality, hospital leadership more and more acknowledges the significance of creating a culture of patient safety. Patient safety culture denotes the shared beliefs, values, and norms held by healthcare providers and staff across the organization that affect their actions and

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behaviors. Patient safety culture can be assessed by identifying what is valued and which attitudes and behaviors are appreciated, encouraged, anticipated, and tolerated concerning patient safety. Establishing a culture of patient safety is crucial on a wide scale as it exists at various levels: within healthcare systems, hospitals, departments, and units. (Sorra et al., 2021)

The Agency for Healthcare Research and Quality (AHRQ) Surveys on Patient Safety CultureTM (SOPSTM) Hospital Survey (HSOPS 1. 0) was first made available in 2004 and has been extensively utilized both in the United States and globally. Throughout the years, AHRQ received input from users and stakeholders regarding proposed modifications to the survey. Based on this input, AHRQ created and conducted pilot testing for an updated version of the survey, the SOPS Hospital Survey 2. 0 (HSOPS 2. 0), which was launched in 2019. (Sorra et al., 2019)

Research conducted at Mitra Medika Tanjung Mulia Hospital Medan in 2021 regarding the Analysis of the Implementation of Patient Safety Culture with the AHRQ Model using 12 Dimensions of Patient Safety Culture. (Juliani et al., 2021) Same as the research conducted by RSUD Dr. R.M. Djoelham Binjai City in 2020 about An Overview of Patient Safety Culture with the AHRQ (Bahri et al., 2023), And also research conducted in United States Hospitals on Patient Safety Culture Assessment using the Agency for Healthcare Research and Quality (AHRQ) (Azyabi et al., 2022). Some of the studies presented used a survey issued by AHRQ in 2004.

In this study used the measurement of safety culture according to the Agency for Healthcare Research Quality (AHRQ, 2019) version 2.0 changes from version 1.0 in 2004 which can be measured from the perspective of hospital staff consisting of 10 dimensions including: teamwork, staffing and work speed, organizational learning for continuous improvement, response when errors occur, supervisors support patient safety, communication about errors, openness of communication, number of error reports, hospital management supports patient safety, and job rotation and exchange of information. (Sorra et al., 2019)

RSU St. Madyang is one of the private type C hospitals located in the city of Palopo. The hospital has a quality assurance unit and a patient safety team. As part of the health service system, RSU St. Madyang has provided inpatient, outpatient, emergency and investigative examination services in the form of promotive, preventive, curative and rehabilitative efforts where patient safety is the main priority which results in a large number of patients who must be treated so that adding tasks, procedures, and tools that must be used will increase the risk of errors in service.

Based on observations and interviews conducted, it was found that patient safety incident reporting at the hospital only began in 2023 and 2024. Although there were several cases of Adverse Events (AEs), no official reports had ever been documented in previous years. This condition indicates a weakness in the patient safety incident reporting system, which could hinder efforts to improve the quality of care and patient safety. With the recent initiation of incident reporting, further evaluation is needed to understand the factors that influence the patient safety culture and to identify efforts that can be made to enhance incident reporting consistently and effectively.

Based on patient safety incident data at RSU St. Madyang Palopo in 2023, there were 7 reported cases, 3 including Improbable Events (KTD), 1 case of Near Injury Event (KNC), and 3 cases of Potential Injury Events (KPC). Meanwhile, from January to July 2024 there were 9 cases, all of which were included in the category of Unexpected Events (KTD). With the increasing number of patient safety incidents from 2023 to mid-2024, researchers are interested in measuring the patient safety culture of all employees at St. Madyang Hospital, Palopo City in 2024, in order to achieve patient safety so that it can reduce unexpected incidents in the

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hospital. Therefore, on the basis of these issues, the researcher aims to describe the patient safety culture based on the AHRQ method among employees at St. Madyang Hospital, Palopo City.

2. Method

The research used quantitative methods with a cross-sectional study design, was conducted at St. Madyang Hospital, Palopo City. The population in this study were employees in the work area of St. Madyang Hospital, Palopo, regardless of employment status, with a total population of 214 respondents, with a sample size of 107 respondents. The sample was obtained using systematic random sampling. The technique for determining the sample in this study is by:

a. Making a complete list of all medical personnel at St. Madyang Hospital.
b. Selecting medical personnel according to the sample size, namely each multiple of 2 is a selected sample, with a total of 107 samples which is 50% of the total population. (Purnama, 2022)

The data used in this study consists of primary and secondary data**.** Primary data was obtained from the Agency for Healthcare Research and Quality (AHRQ) questionnaire, which measures hospital employees' perceptions of patient safety culture across 10 dimensions using a Likert scale. Secondary data was gathered through document review, which includes the hospital profile to understand its background, data on the total number of employees to assess the hospital's workforce size, and data on the number of patient safety incidents to evaluate the frequency and reporting of safety issues within the hospital.

In the 10 dimensions of Patient Safety Culture, positive perceptions are calculated based on respondents' answers to each question. A positive response is called if the respondent's answer strongly agrees/agrees to items/questions with positive words and strongly disagrees/disagrees to items/questions with negative words, a negative response if the respondent's answer strongly disagrees/disagrees to items with positive words and strongly agrees/agrees to items/questions with negative words. Categorization is based on the average quintile of positive responses, the details are as follows: very weak (if the respondent's positive response is at: 0.0%-20.0%); weak (if the respondent's positive response is at: 21.0%-40.0%); Intermediate (if the respondent's positive response is at: 41.0%-60.0%); strong (if the respondent's positive response is at: 61.0%-80.0%) and very strong (if the respondent's positive response is at: 81.0%-100%). (Henik Saefulmilah & Prasetyo, 2024) Data analysis in this study was conducted using descriptive statistics to present the distribution and percentage of responses across the dimensions of patient safety culture.

3. Results and Discussion

Table 2.

Characteristics of Respondents

Variable	Category	Frequency	Percentage (%)
Work unit	Emergency Room (IGD)	6	**5,6%**
	Intensive Care Unit (ICU)	2	**1,9%**
	Outpatient Installation	10	**9,3%**
	Inpatient Installation	20	**18,7%**
	Pharmacy	21	**19,6%**
	Laboratory	5	**4,7%**

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	Radiology	3	**2,8%**
	Physiotherapy	2	**1,9%**
	Comprehensive Emergency Obstetric Neonatal Care	3	**2,8%**
	Perinatology	9	**8,4%**
	Admission / Medical Records / BPJS Staff	8	**7,5%**
	OK/RR	3	**2,8%**
	Nutrition / Kitchen / Waiter	5	**4,7%**
	Office / IT	10	**9,3%**
Gender	Male	15	**14,1%**
	Female	92	**85,9%**
Age	< 30 Years	55	**51,4%**
	> 30 Years	52	**48,6%**
Length of Service	Less than 1 year	17	**16%**
	1-5 years	48	**44,8%**
	6-10 years	33	**30,8%**
	11-15 years	6	**5,6%**
	Above 15 years	3	**2,8%**
Position/Profession	Pharmacist	3	**2,8%**
	Pharmacist Assistant	9	**8,4%**
	Midwife	11	**10,3%**
	Nurse	30	**28%**
	Admission	3	**2,8%**
	BPJS Staff	2	**1,9%**
	Medical Records	3	**2,8%**
	Pharmacy Technical Personnel	11	**10,3%**
	Physiotherapist	2	**1,9%**
	Nutritionist	2	**1,9%**
	General Practitioner	2	**1,9%**
	Dentist	1	**0,9%**
	Specialist Doctor	8	**7,5%**
	Administrative Staff	4	**3,7%**
	Management Staff	6	**5,6%**
	Laboratory Staff	4	**3,7%**
	Radiographer	3	**2,8%**
	Waiter	3	**2,8%**

Source: Primary Data, 2024

Table 2 shows that respondent characteristics based on work units in the Emergency Room as many as 6 (5.6%), Intensive Care Unit (ICU) as many as 2 (1.9%), Outpatient Installation as

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many as 10 (9.3%), Inpatient Installation as many as 20 (18.7%), Pharmacy as many as 21 (19.6%), Laboratory as many as 5 (4.7%), Radiology as many as 3 (2.8%), Physiotherapy as many as 2 (1.9%), Ponek as many as 3 (2.8%), Perinatology as many as 9 (8.4%), Admissions/Medical Records/BPJS as many as 8 (7.5%), OK/RR as many as 3 (2.8%), Nutrition/Kitchen/Waiter as many as 5 (4.7%), and Office/IT as many as 10 (9.3%). When viewed by Gender, it shows that most of the respondents are women, namely 92 (85.9%), while men are 15 (14.1%). Based on age, the age of <30 years was 55 (51.4%), while the age of >30 years was 52 (48.6%).

Based on the characteristics of length of service, the highest number of those working for 1-5 years was 48 (44.8%), then 6-10 years was 33 (30.8%), less than 1 year was 17 (16%), 11-15 years was 6 (5.6%), while the lowest number of those working for more than 15 years was 3 (2.8%). As for the Position/Profession, the largest number of respondents were nurses, namely 30 (28%), midwives as many as 11 (10.3%), pharmaceutical technical staff as many as 11 (10.3%), pharmacist assistants as many as 9 (8.4%), specialist doctors as many as 8 (7.5%), management staff as many as 6 (5.6%), administrative staff as many as 4 (3.7%), laboratory assistants as many as 4 (3.7%), pharmacists as many as 3 (2.8%), admissions as many as 3 (2.8%), medical records as many as 3 (2.8%), radiographers as many as 3 (2.8%), waiters as many as 3 (2.8%), BPJS staff as many as 2 (1.9%), physiotherapists as many as 2 (1.9%), nutritionists as many as 2 (1.9%), general practitioners as many as 2 (1.9%), and the lowest was dentists as many as 1 (0.9%).

Table 3.
All 10 Dimensions of Patient Safety Culture at St. Madyang Hospital in 2024

Element	Response			N	%	Culture Category
	+	±	-			
Teamwork						
We support each other	91	13	3	107	85%	**90% strong**
When there is a job that needs to be done quickly, we work together to do it	98	7	2	107	92%	
If one staff is busy, then other staff will help	98	5	4	107	92%	
Staffing and work speed						
In this unit we respect each other	99	6	2	107	93%	**60% medium**
Staff in this section will work longer hours than normal for patient care	64	19	24	107	50%	
We are required to work faster with a lot of work	27	21	59	107	25%	
We have adequate staff to handle the work at hand	77	14	16	107	72%	
Organizational Learning for Continuous Improvement						
We are always proactive in improving patient safety	104	0	3	107	97%	**74% medium**

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Sometimes we use additional/temporary staff	54	25	28	107	50%	
We always evaluate efforts to improve patient safety	96	10	1	107	90%	
Patient safety is never sacrificed to get the job done	91	11	5	107	85%	
We have a patient safety issue in this unit	51	28	28	107	48%	
Response to errors						
Mistakes are resolved together	98	6	3	107	92%	**64% medium**
Mistakes that occur lead to positive change	85	15	7	107	79%	
Only occasionally do serious mistakes occur in this unit	67	26	14	107	63%	
When a case is reported, the focus is on the staff, not the problem	42	26	39	107	39%	
Staff are afraid of their mistakes being recorded	32	32	43	107	30%	
Procedures and systems in this unit prevent mistakes from occurring	84	18	5	107	78%	
Supervisor Supports Patient Safety						
Supervisor is happy when he/she sees work done according to patient safety procedures	104	3	0	107	97%	**81% strong**
Supervisor is very serious about considering staff suggestions	93	13	1	107	87%	
When work pressure is high, supervisor wants everything done quickly even if he/she has to take shortcuts	53	22	32	107	50%	
Supervisor always discusses the importance of patient safety	96	10	1	107	90%	
Communication About Error Occurrence						
We will evaluate the case that occurred	99	6	2	107	93%	**91% strong**
We were informed about the things regarding the errors that occurred in this unit	94	11	2	107	88%	
We discussed how to prevent the error from happening again	99	6	2	107	93%	
Openness of communication						
Staff are free to speak up when they see something that has a negative impact on patients	80	16	11	107	75%	**70% medium**
Staff feel free to ask those in higher positions in making decisions	76	21	10	107	71%	
Staff are afraid to ask questions if they see something that is not normal	68	22	17	107	64%	

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Number of Error Reports						
When an error occurs, but is caught and corrected before it reaches the patient, how often is it reported (Near Miss Events)	31	60	16	107%	29%	**33% weak**
When an error occurs, but does not have the potential to harm the patient, how often is it reported? (Non-Injurious Events)	36	51	20	107	34%	
When an error occurs that could have harmed the patient, but no harm was done to the patient, how often is it reported? (Potentially Injurious Events)	40	45	22	107	37%	
Hospital Management supports Patient Safety						
hospital management creates a work climate that improves patient safety	79	23	5	107	74%	**67% medium**
hospital management puts patient safety first	93	12	2	107	87%	
management only does something when a case or error occurs	44	29	34	107	41%	
change of tasks and exchange of information						
problems usually arise when a patient is transferred from one department to another	33	36	38	107	31%	**51% medium**
the units in the hospital do not communicate well with each other	58	26	23	107	54%	
there is good cooperation between hospital units	72	30	5	107	67%	
important patient care information is often missed during shift changes	32	34	41	107	30%	
working with staff from other departments is often unpleasant	55	32	20	107	51%	
problems often arise in exchanging information between hospital units	37	39	31	107	35%	
hospital units work well together to provide the best care	84	19	4	107	79%	
shift exchanges being a problem for patients in the hospital	61	30	16	107	57%	
AVERAGE						**68% medium**

Source: Primary data, 2024

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Based on Table 3, it shows that the Patient Safety Culture Research at St. Madyang Regional Hospital in 2024 used 10 dimensions with a total of 107 respondents with the overall results of the cultural category of 68% being a moderate cultural category. The teamwork dimension consisted of 3 questions, namely we support each other getting 91 positive responses, 13 neutral, and 3 negative, with a positive response percentage of 85%. the question when there is work that needs to be completed quickly, we work together to do it got a positive response of 98, neutral 7, negative 2, with a positive response percentage of 92%, and the question if one staff is busy, then other staff help get 98 positive responses, neutral 5 and negative 4 with a positive response percentage of 92%. The overall results show a strong cultural category with a percentage of 90%.

In the dimensions of staffing and work speed, there are 4 questions, namely the question on this unit we respect each other received a positive response of 99, neutral 6, negative 2, with a positive response percentage of 93%, the question of staff in this section will work longer than normal working hours for patient services received 64 positive responses, neutral 19, negative 24, with a positive response percentage of 50%, then the question we are required to work faster with a lot of work received a positive response of 27, neutral 21, negative 59, with a positive response percentage of 25%, and the question we have adequate staff to handle the existing work received a positive response of 77, neutral 14, negative 16, with a positive response percentage of 72%. The overall results show a medium cultural category with a percentage of 60%.

Next, in the dimension of organizational learning for continuous improvement, there are 5 questions, the question we are always active in order to improve patient safety received a positive response of 104, neutral 0, negative 3, with a positive response percentage of 97%, the question sometimes we use additional/temporary staff received a positive response of 54, neutral 25, negative 28, with a positive response percentage of 50%, the question we always evaluate efforts to improve patient safety received a positive response of 96, neutral 10, negative 1, with a positive response percentage of 90%, the question patient safety is never sacrificed to complete the work received a positive response of 91, neutral 11, negative 5, with a positive response percentage of 85%, and the question we have problems regarding patient safety in this unit received a positive response of 51%, neutral 28, negative 28, with a positive response percentage of 48%. The overall results show a medium cultural category with a percentage of 74%.

Meanwhile, for the error response dimension, there are 6 questions, the question of existing errors resolved together received a positive response of 98, neutral 6, negative 3, with a positive response percentage of 92%, the question of errors that occur make positive changes received a positive response of 85%, neutral 15, and negative 7, with a positive response percentage of 79%, the question of only occasionally serious errors occur in this unit received a positive response of 67, neutral 26, negative 14, with a positive response percentage of 63%, the question of if there is a case report, the focus is on the officer, not the problem received a positive response of 42%, neutral 26, negative 39, with a positive response percentage of 39%, the question of staff being afraid if their errors are stored in documents received a positive response of 32, neutral 32, negative 43, with a positive response percentage of 30%, and the question of procedures and systems in this unit can prevent errors from occurring received a positive response of 84, neutral 18, negative 5, with a positive response percentage of 78%. The overall results show a medium cultural category with a percentage of 64%.

Next, in the supervisor dimension supporting patient safety, there are 4 questions, the question my supervisor is happy when he sees work done according to patient safety procedures received a positive response of 104, neutral 3, negative 0, with a positive response percentage of 97%, the question my supervisor is very serious in considering his staff's suggestions

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received a positive response of 93, neutral 13, negative 1, with a positive response percentage of 87%, the question when work pressure is created, my supervisor wants everything to be done quickly even if he has to take shortcuts received a positive response of 53, neutral 22, negative 32, with a positive response percentage of 50%, and the question my supervisor always discusses the importance of patient safety received a positive response of 96, neutral 10, negative 1, with a positive response percentage of 90%. The overall results show a strong cultural category with a percentage of 81%.

Furthermore, in the communication dimension about the occurrence of errors, there are 3 questions, the question we will evaluate the case that occurred received a positive response of 99, neutral 6, negative 2 with a positive response percentage of 93%, the question we were informed about things regarding the errors that occurred in this unit received a positive response of 94, neutral 11, negative 2, with a positive response percentage of 88%, and the question we discussed how to prevent errors from happening again received a positive response of 99, neutral 6, negative 2, with a positive response percentage of 93%. The overall results show a strong cultural category with a percentage of 91%.

In the dimension of openness of communication, there are 3 questions, the question of staff being free to speak when they see something that has a negative impact on patients received a positive response of 80, neutral 16, negative 11, with a positive response percentage of 75%, the question of staff feeling free to ask those who are higher in position in making decisions received a positive response of 76, neutral 21, negative 10, with a positive response percentage of 71%, and the question of staff being afraid to ask if they see something unnatural received a positive response of 68, neutral 22, negative 17, with a positive response percentage of 64%. The overall results show a medium cultural category with a percentage of 70%.

Next, the dimensions of the number of error reports consist of 3 questions, the question when an error occurs, but is caught and has been corrected before reaching the patient, how often is it reported (Near Miss Events) received a positive response of 31, neutral 60, negative 16, with a positive response percentage of 29%, the question when an error occurs, but does not have the potential to injure the patient, how often is this reported? (Non-Injury Events) received a positive response of 36, neutral 51, negative 20, with a positive response percentage of 34%, and the question when an error occurs that could injure the patient, but no injury occurs to the patient, how often is this reported? (Potential Injury Events) received a positive response of 40, neutral 45, negative 22, with a positive response percentage of 37%. The overall results show a weak cultural category with a percentage of 33%.

Meanwhile, in the dimension of hospital management supporting patient safety, there are 3 questions, the question of hospital management creating a work climate that improves patient safety received a positive response of 79, neutral 23, negative 5, with a response percentage of 74%, the question of hospital management placing patient safety as the most important thing received a positive response of 93, neutral 12, negative 2, with a positive response percentage of 87%, and the question of management only doing something when a case or error occurs received a positive response of 44, neutral 29, and negative 34, with a positive response percentage of 41%. The overall results show a medium cultural category with a percentage of 67%.

And the last in the dimension of changing tasks and exchanging information there are 8 questions, the question usually problems will arise when a patient is transferred from one section to another received a positive response of 33, neutral 36, negative 38, with a positive response percentage of 31%, the question of units in the hospital do not communicate well with each other received a positive response of 58, neutral 26, negative 23, with a positive response percentage of 54%, the question of there is good cooperation between hospital units received a positive response of 72, neutral 30, negative 5, with a positive response percentage of 67%, the

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question of important patient care information is often missed during the change of duty hours received a positive response of 32, neutral 34, negative 41, with a positive response percentage of 30%, the question of working with staff from other units is often unpleasant received a positive response of 55, neutral 32, negative 20, with a positive response percentage of 51%, the question often arises problems in exchanging information between hospital units received a positive response of 37, neutral 39, negative 31, with a positive response percentage of 35%, The question of hospital units working together well in providing the best care received 84 positive responses, 19 neutral, 4 negative, with a positive response percentage of 79%, and the question of shift exchanges being a problem for patients in the hospital received 61 positive responses, 30 neutral, 16 negative, with a positive response percentage of 57%. The overall results show a medium cultural category with a percentage of 51%.

This research employs the AHRQ method to examine the patient safety culture among the staff of St. Madyang Hospital, located in Palopo City. The results of this research reveal that the dimension of teamwork within the hospital scored positively at 90%, which is classified as a strong culture. This aligns with a study conducted in Afghanistan, which indicated that the dimensions of "teamwork across units" and "teamwork within units" had the highest positive averages. (Jabarkhil et al., 2021) Teamwork services can influence the quality and safety of patients. Collaboration within a cohesive unit demonstrates how well that unit can exhibit unity and function as a team. Strong collaboration fosters a positive environment and atmosphere for the entire team and facilitates the achievement of organizational objectives. This is further supported by research in Turkey indicating that teamwork and cooperation among nurses are vital for enhancing patient safety. (Soyer Er & Gül, 2024) Findings from a study in Norway revealed that training in teamwork and communication enhanced patient safety culture scores, suggesting that improvements in this area could lead to a decrease in adverse event rates. (Vikan et al., 2023)

Furthermore, regarding the dimensions of Personnel and Work Speed, there was a favorable response of 60%, indicating that the culture of patient safety is at a medium level. The speed of work is also characterized by the lack of adequate staff and the readiness to manage the patient load in less crowded services. An excessive workload affects the implementation of patient safety negatively; the heavier the workload, the greater the impact on the decline in patient safety practices. (Mutia & Dhamanti, 2023) Research conducted in Iranian hospitals demonstrated that every unit of nurse performance improvement enhanced patients' safety culture by 0. 360 units. Moreover, each one-unit rise in a nurse's fatigue could reduce his or her performance by 0. 860 units. (Niri, 2025)

Continued on dimensions of organizational learning, the results obtained were 74%, indicating that it falls into a medium culture category. The studies conducted in Sweden suggest that when mistakes happen in the Swedish context, the problem-solving model fails to operate, leading to reduced organizational learning and limited system enhancements. (Granel-Giménez et al., 2022) Moreover, surveys conducted in Scottish hospitals revealed that regarding patient safety, there is a favorable reaction to organizational learning and ongoing improvement. Work procedures and incidents that take place can lead to continuous enhancement. Additionally, patient safety may be elevated by enhancing the skills and knowledge of staff required to manage incidents. (Azyabi et al., 2021)

In the dimension of response to errors, the results showed that 64% was a medium culture. The response to mistakes is the most crucial action taken by the patient safety team following the reporting of a patient safety incident, as this is carried out to assess the degree to which investigative measures are necessary in the incident. All teams and personnel are provided with comprehensive information regarding the incident that occurred, followed by feedback on improvement implementations and collaborative discussions on error prevention options.

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(Anggraini, 2021) Research conducted in the United States reveals that fear of repercussions is noted in the majority of studies we examined as a significant obstacle to reporting medical mistakes. Some of the sources of fear are subject to modification, such as the fear of being held accountable for the mistake or the fear of job loss. Transforming workplace culture and developing strategies to address the reporting of medical mistakes is a critical step in overcoming this obstacle. A workplace culture that fosters patient safety, promotes error reporting, and enforces system changes is vital. (Aljabari & Kadhim, 2021)

The dimension of supervisor support for patient safety was recorded at 81%, indicating a robust safety culture. In supervisory activities, it goes beyond mere oversight between the head of the room and the nurse executing tasks; the head's supervision is part of an effort to enhance quality and efficient services. Insufficient supervision from the head of the room can diminish the quality of nursing services and may result in a rise in patient safety incidents. (Suhesti et al., 2024). This aligns with the findings from the analysis of patient safety incidents at the Surabaya Islamic Hospital, which is primarily characterized by near-miss incidents rated green. Feedback and supervision impact the frequency of patient safety incidents, exhibiting a difference of 22. 2% and 52. 5%, respectively. This research indicates that feedback and supervision have an effect on the patient safety incidents within the hospital. (Adriansyah et al., 2022)

Next, the dimension of communication regarding errors revealed a favorable response of 91%, signifying a robust safety culture. Discussing errors is also crucial in reducing the incidence of patient safety events. The communication employed between nurses and other healthcare professionals to report the progression of the patient's condition can utilize the effective communication method SBAR. SBAR communication is a method that incorporates logistical tools to arrange information so that it can be delivered to others with accuracy and efficiency. Effective SBAR communication ensures that patient data is conveyed accurately and efficiently, preventing errors in the transmission or reception of the information shared. Clear information will facilitate other medical personnel in comprehending the results of developments and guarantee patient safety.(Anam et al., 2022)

In the dimension of communication openness, this research revealed a favorable response of 70%, placing it within the medium culture category. The significance of transparent communication is emphasized by the views of various joint commissions from different nations, which state that up to 80% of patient safety incidents stem from miscommunication among professionals. (Hafezi et al., 2022) To cultivate nonpunitive workspaces, hospital administrators and nurse managers ought to exhibit a willingness to change, encourage transparent communication, and create secure environments where nurses can openly address patient safety-related concerns and mistakes, which will subsequently enable the organization to derive lessons from those mistakes and enhance the quality and safety of patient care. (Lee & Dahinten, 2021)

Furthermore, In the dimension of of reporting patient safety incidents, only 33% fall into the weak category. Incident reporting figures can offer solutions to the medical services provided to patients. As mandated in patient safety by the Regulation of the Minister of Health No. 11 of 2017, hospitals are required to report incidents to the National Patient Safety Committee to enhance quality through the reporting of patient safety incidents. (Alfiyyah, Modjo, 2024) Accurately and efficiently measuring adverse events and developing standardized methods for identifying and concentrating on preventable adverse events are essential for aiding individuals responsible for enhancing safety. This observation indicates that if hospitals possessed data that were more reliable and systematically collected, it might be possible to improve monitoring, decrease adverse event rates, and share enhancement strategies through careful analysis of interventions. (Bates et al., 2023)

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The dimension of hospital management in supporting patient safety, it is 67% categorizing it as medium culture. The research conducted in hospitals across Riyadh, Saudi Arabia, revealed a correlation between the roles held within the hospital and the overall level of awareness; this is especially evident in supervisory and management roles compared to other clinical roles. This finding may stem from the fact that leaders and managers possess a proper and accurate understanding of the current situation regarding patient safety challenges, which empowers them to formulate an action plan when necessary. Furthermore, it is essential for managers and leaders to consistently remain informed about patient safety issues and to exert a more significant influence on the development of hospital safety culture than other clinicians or non-managerial staff. (Albaalharith & A'Aqoulah, 2023)

And in the dimensions of changing tasks and exchanging information, there was a favorable response of 51%, which falls into the medium category. Transfers and changes (handoffs and transitions) are closely tied to the system of collaboration and coordination among health workers during the shift change. This process will significantly jeopardize patient safety if not performed correctly and professionally, as the patient information obtained must be received effectively. The success rate of the handoff and transition process is dependent on the awareness among health care providers regarding the significance of handoff and transition procedures. Therefore, staff education and training are essential to ensure the execution of improved handovers and transitions, necessitating good cooperation from all related services. (Wianti et al., 2021)

The findings of this study demonstrate that patient safety culture is concretely reflected in the attitudes and behaviors of healthcare personnel, including compassion, responsiveness, and efficiency in service delivery. These results suggest that various dimensions of patient safety can be identified through direct interactions between healthcare providers and patients. Consistent with Guldenmund's (2010) perspective, safety culture plays a pivotal role in shaping organizational behavior in relation to risk management. (Juliani et al., 2021) The implications of these findings highlight the necessity for hospitals to continuously reinforce patient safety culture as an integral component of their overall quality improvement strategies. (Bahri et al., 2023) Furthermore, the assessment of patient safety culture serves as a valuable evaluative instrument to determine the extent to which safety-related values are internalized by staff across different organizational levels, while also identifying specific areas that require ongoing improvement. Strengthening the safety culture thus contributes not only to enhanced service quality but also to the hospital's institutional reputation and the public's trust. (Henik Saefulmilah & Prasetyo, 2024)

4. Conclusion

Based on the results of the study, it shows a moderate safety culture, where the lowest positive response value for reporting patient safety incidents is 33%. It is essential to motivation employees regarding the reporting of incidents in the hospital, as consistent reporting can subsequently facilitate easy access and safety in reporting, aimed at promoting safety and guaranteeing that health services will avert accidents or injuries in the future and hospitals must create a strategy to improve patient safety culture. This study used the AHRQ version 2 method which is a development of previous research that only used the AHRQ version 1 method. Updating this study is important because the Ministry of Health's Health Service Research and Quality Agency stated that AHRQ version 1 is no longer accepted in the Database starting in June 2022. Additional research is recommended using the WHO global patient safety action plan 2021–2030 to move towards eliminating avoidable harm in health care.

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