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NURSE INTENTION IN REPORTING PATIENT SAFETY INCIDENT

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Abstract: *Data report on Patient Safety Incident in X Hospital Malang of the year 2018 showed that 64.83% occurred in the nursing unit, 18.5% in the pharmaceutical unit and 49.25% was conducted by the doctor while 7.40% took place in other units. The high rate of Patient Safety Incidents in the nursing unit is in accordance with the distribution of Patient Safety Incident Report published by KKPRS in 2011, where it is accounted for the highest incidence rate. Given the patient safety culture in X Hospital Malang is still inadequate, leading to the possibility of underreporting or hidden report.* ***This study aimed to*** *analyze the patient safety culture effect towards nurses' desire in reporting Patient Safety Incident with the Perception of Standard Operating Procedures (SOPs) on the flow chart of Patient Safety Incident reporting as the intervening variable in X Hospital Malang.* ***The research method*** *was descriptive analysis with cross sectional quantitative approach (quantitative cross-sectional study). The primary data was collected by distributing questionnaires to nurses while Partial Least Square (PLS) was used as the analysis method, a structural equation analysis (SEM). The result of this study is considered quite well, from the total of 12 cultural dimensions, 7 are rated as poor, 1 is rated as average while the remaining 4 are rated as good. The perception of nurses towards the SOP on the flow chart of Patient Safety Incident Reporting is considered good, the understanding and the ability to distinguish Patient Safety Incident, creating reports, and performing grading are considered poor, although te understanding and the ability to identify incident are good. The desire of nurses in reporting Patient Safety Incident is rated as average even though the desire to report adverse and sentinel events is considered good, but the desire to report near miss and no harm events is poor.* ***The result from*** *this study conclude that patient safety culture has positive and significant impact on the perceptions of nurses towards sop on patient incident reporting flowchart. their perceptions positively and significantly affect their willingness to report patient safety incident.* ***This study found*** *that patient safety culture has positive and significant impact effect to their willingness to report patient safety incident through their perceptions towards sop on patient safety incident reporting flowchart*

Keyword*: Patient Safety Incident, underreporting, Patient Safety Culture, Perception, Desire, Nurses*

Introduction

In the past, it was very often that the first reaction towards patient safety incidents (PSI), hereinafter referred to an incidentoccurred in the hospital was to blame the involving staff and to carrie out punishments. This has led the staff to be reluctant to report when an incident occurs.

According to Noble and Provonost (2010) unreported or hidden Patient Safety Incident will contribute to the inability of health services to accurately identify patient safety risks. There are several factors that lead health

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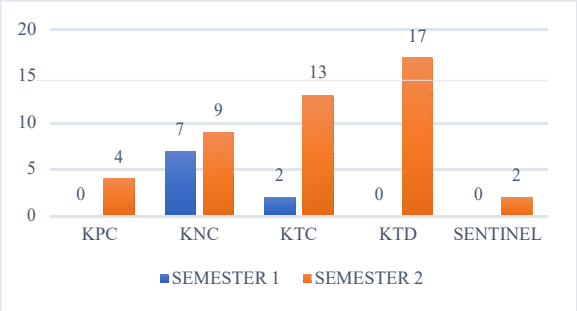
workers to be reluctant to report the Patient Safety Incident, which are due to their fear of being punished (fired from a job), fear of lawsuits, unclear reporting system, complex administration and documentation procedure and unclear follow-up of incidents that have been reported.(Noble, Pronovost, & Fccm, 2010)

There is a problem that often hinder the incident report which is reports are perceived as nurses' jobs e.g. reports are often being hidden/unreported. Data from the United States showed that only about 4-50% of the true incidence rate was reported, while data from the United Kingdom showed that at least as much as 22-39% of medical errors are not reported. Hidden Patient Safety Incident caused bias to the Patient Safety Incident data.

Hospital Patient Safety Committee/*Komite Keselamatan Rumah Sakit* (HPSC/KPRS) has made a Patient Safety Incident reporting guideline in 2015 with 13 points of incident reporting flowchart to the hospital patient safety team (internal) which then was translated into Patient Safety Incident Reporting.(KKP-RS, 2008)

Patient Safety Incident Report in 2018 was divided into two semesters which are I and II semester. During the first semester, 9 incidents were reported while the number increased to 45 in the second semester as illustrated in the graph below.



Graph 1.
PSI report in X Hospital Malang

Based on PSI Data Report of the year 2018 in X Hospital Malang, 64.83% occurred in nursing unit, 18.5% in pharmaceutical unit while 49.25% carried out by the doctor, and 7.40% occurred in other units.

The high rate of Patient Safety Incidents is in accordance with the distribution of Patient Safety Incident Report published by KKPRS in 2015, in which the nursing unit accounted for the highest incidence rate. (Djoti, 2019). The highest percentage increase occurred in the inpatient room with a percentage of 30%, compared to the same month in 2016.(Handy & Kusumapradja, 2018)

Based on the above data, the nursing unit, especially inpatient contributed in the high reporting number thus author wished to study the nursing staff working in inpatient unit, Intensive

Care Unit, Operating Room, Emergency unit and the outpatient unit because they involved directly with patients and the number of nurses in the hospital is the highest as research object.

While to know the culture, it was necessary to conduct patient safety culture measurement in the hospital Measurement survey used HSPSC (Hospital Survey on Patient Safety Culture) questionnaire formulated by AHRQ (American Hospital Research and Quality) in 2007. HSPSC is an instrument designed to measure the hospital staff opinion on the issue of patient safety, medical error and incident reporting , This survey consists of 42 items of questions that are divided into several sections, namely; 18 questions about the unit, 4 questions about the manager of the unit, 6 questions about the communication within the unit, 3 questions about the frequency of reporting incidents in the unit and 11 questions about the hospital.(Authors, 2013)

Overall 42 question items reflecting the culture of patient safety are categorized in 12 dimensions. These dimensions are cooperation within the unit, expectations and actions of managers in promoting patient safety, organizational learning with continuous improvement, management support for patient safety, perceptions of patient safety, communication and feedback on errors, openness of communication, frequency of incident reporting, cooperation between units, staffing, information handover and patient transfer, non- punitive responses to errors.

Results of patient safety culture survey in X Hospital Malang in 2018 using HSPSC with the most respondents were nurses (53%). The survey showed a strong cultural dimension of sustainable improvement, feedback and

communication to errors as well as cooperation within the unit, weak cultural dimension of expectations and actions of managers in promoting patient safety, non-punitive responses to errors, and staffing.

Given the weak patient safety culture, as well as increased Patient Safety Incidents in 2018 was a phenomenon. If the increase of the incident was a real data, then on the one hand it showed the reporting system is good, but on the other hand indicated the insufficient quality of service either one of which was resulted by the unreported condition of the potential for injury or nearly injured so that it became incident before being prevented. In the PSI report of X Hospital, adverse event is higher than the potential for ijurnly or nearly injured. If staff was diligently reporting potential for injury or nearly injured events then it was expected to lead to the absence of adverse events. But in the X Hospital Malang, the amount of near miss events is fewer than adverse events so it can be assumed that many reports were unreported/hidden (underreporting). Weak patient safety culture can contribute to the occurrence of underreporting or hidden incidents of any kind. To determine the incidence of which is hidden, it is necessary to evaluate the desirability of health workers in making Patient Safety Incident report. Given that one factor contributing to the underreporting is obscurity reporting system, it is necessary also to be evaluated on the perceptions of Patient Safety
Incident reporting flowchart.

The study result from Douglas J. Noble (2010) stated that underreporting is important to know the potential occurrence of incidents. System that is too complex and cumbersome would result in the inaccurate information, causing the characteristic that becomes the root of the problem to be biased. Incident reporting system requires a good understanding, reduction of bias and openness so as to produce a reliable and measurable progress. When the system is easy to understand and simple to use, it is expected to give better benefits.

Motivation of this study is the author is interested in quality and patient safety improvement. X Hopital Malang as a type C private hospital with many patients have to provide services that are patient safety oriented, but there are obstacles in its implementation. Whether it is related with the culture, given the patient safety culture in the X Hospital is still weak, so there is no intention from nurses to report the incident. Author wished to find out the most contributed factors to their intention in reporting the incident. Because the reported incidents will be helpful in obtaining valid data to know the causing detail of incident as well as its prevention. The numerous underreporting especially in near miss event also made the defense system of incident was not working according to the Swiss Cheese Model theory.

The purpose of this study was to determine the nurse intention in reporting Patient Safety Incidents (PSI).

The benefit of this study is that it can be used as input to the management of X Hospital in making policy and decisions related to the implementation of patient safety, developing the incident reporting and improving the safety culture so as to improve the quality of the hospital.

Method

The method used in this research is descriptive analysis method with cross sectional quantitative approach (quantitative cross- sectional study) with causality research design and PLS analysis models.

The study analysis was carried out by collecting primary and secondary data. Primary data was collected by distributing questionnaires to nurses working in inpatient, outpatient, emergency, operating room, and intensive care unit.

Secondary data was obtained by collecting data from patient safety culture survey, SOP on Patient Safety Incident Reporting and PSI Data Report of X Hospital Malang in 2018.

A hundred respondents were selected using purposive sampling technique based on inclusion criteria of nurses whose own more than 1 year of tenure at X Hospital Malang.

The study was conducted from September- October 2019.

Result and Discussion Descriptive analysis

1. **Description of tenure at the hospital and unit, working hours within a week**

Table 1.

Respondents characteristic in X Hospital Malang

BASED ON	CRITERIA	F	%
Tenure at the	1-5 years	9	9%
	6-10 years	81	81

hospital			%
	11-15 years	9	9%
	16-20 years	1	1%
	21 years or more	0	0
Tenure at the unit	1-5 years	40	40 %
	6-10 years	56	56 %
	11-15 years	4	4
	16-20 years	0	0
	21 years or more	0	0
Working hours within a week	<20 hours a week	2	2%
	20-39 hours a week	14	14 %
	> 40 hours a week	84	84 %

In the table of tenure at the hospital characteristic, it can be seen that the nursing staff with the tenure of 6-10 years has the highest percentage of as much as 81%, followed by 1-5 years and 11-15 years with

In the table of tenure at the unit characteristic, it can be seen the nursing staff with the most tenure is 6-10 years with a percentage of 56%, followed by a tenure of1- 5 years of work as much as 40% respectively, 11-15 years as much as 4% and no nursing staff with over 16 years of tenure at the unit. This illustrates the mutation of staff from one unit to another, and most of thestaff settled in the unit for a long time.

In the table above, it can be seent that the majority of 84% works more than 40 hours per week while 14% works for 20-39 hours per week and 20% works less than 20 hours per week. This illustrates the heavy and imbalance workload.

2. Frequency Distribution Description of Patient Safety Culture

Table 2.

Research Variable Frequency Distribution Result of Patient Safety Culture

Dimension	Value	Implementation
1. Cooperation within unit	3.80	strong
2. Expectations and actions of managers in promoting patient safety	2.57	weak
3. Organizational leraning with continuous improvement	2,59	weak
4. Management support towards patient safety	2.56	weak
5. Perceptions of patient safety	2.58	weak
6. Communication and feedback on errors	3.84	strong
7. Open communication	2.37	weak
8. Event reporting	3.20	moderate

frequency		
9. Cooperation between units	3.93	strong
10. Staffing	2.47	weak
11. Information handover and patient transfer	3.42	strong
12. Non-punitive reaction to errors	2.55	weak
The dimension average	**2.99**	**moderate**

Overall result from the HSPSC questionnaire in X Hospital Malang shows that patient safety culture valued as moderate with an average value of 2.99. Dimension of patient safety culture with the highest value is cooperation among units (3.93) followed by feedback and communication on errors (3.84), cooperation within unit (3.80) and information handover and patient transfer (3.42), meaning that the safety culture at those 4 dimensions are strong so that it should be maintained.

Dimensions of patient safety culture with the moderate value are incident reporting

the percentage of 9% respectively. And no
nursing staff has over 16 years of tenure at the hospital. frequency (3.20), meaning that the safety culture in the reporting frequency dimension is strong and need to be improved.

While the dimensions of patient safety culture that valued as weak are organization learning with continuous improvement (2,59), perceptions of patient safety (2,58), expectations and actions of managers in promoting patient safety (2.57), management support towards patient safety (2.56), non- punitive reactions to errors (2.55), staffing (2.47), open communication (2,37), which

Description Indicator	Value	Intention
8. Report others during no harm event	2.36	No intention
9. Report others during adverse event	4.14	Intent
10. Report others during sentinel event	4.04	Intent
Dimension average	**3.01**	**Moderate**

The last variable is the nurses intention in reporting PSI obtained moderate value (3.01).
In the variable of nurse intention in

means that the safety culture at these 7 dimensions are weak that it needs to be recreated so that patient safety culture will become a strong culture.

3. Frequency Distributon Description of PSI Reporting Flowchart Perception

Table 3.

Research Variable Frequency Distribution Result of PSI Reporting Flowchart Perception

Indicator Description	Value	Knowledge
1. Understand to identify incident	3.83	Well
2. Able to identify incident	3.63	Well
3. Understand to identify the type of PSI	3.46	Well
4. Able to identify the type of PSI	3.36	Moderate
5. Understand to fill PSI reporting	2.43	Poor
6. Able to fill out PSI reporting	2.61	Poor
7. Understand to perform grading	2.58	Poor
8. Able to perform grading	2.51	Poor
Dimension average	**3.05**	**Moderate**

Perception variable of PSI Reporting Flowchart obtained moderate value (3.05). Seen from the data above, the more advanced part of the flowchart, the lower their understanding and capacity. It can be seen in the term of identifying incident is good, understanding and ability to identify PSI obtained well and moderate value, but lack of understanding and ability in filling out PSI reporting up to grading.

4. Frequency Distributon Description of Nurse Intention in Reporting PSI

Table 4.

Research Variable Frequency Distribution Result of Nurse Intention in Reporting PSI

Description Indicator	Value	Intention
1. Report yourself during near miss event	2.13	No intention
2. Report yourself during potential to harm event	2.02	No intention
3. Report yourself during no harm event	1.80	No intention
4. Report yourself during adverse event	4.17	Intent
5. Report yourself during sentinel event	4.42	Intent
6. Report others during potential to harm event	2.36	No intention
7. Report others during near miss	2,66	No intention

reporting PSI, there are 10 question items representing 5 intentions to report 5 types of PSI while respondents become subject and the intention of respondent to report 5 types ofPSI while witnessing coworkers became the subject of the perpetrators of incidents.

It turned out that the intention to report is not affected by the subjects who committed, but is affected by the impact caused makes someone wants to report whether it is their own willingness or forced.

The nurse intention in reporting PSI is valued moderate, the nurse wants to report incident that affects patient but on the contrary, nurses are unwilling to report incidents that have no impact on the patient.

Hypothesis Testing

1. Direct Impact Hypothesis Testing

Table 5.

The result of direct impact hypothesis

Exogenous	Endogenous	Path Coefficient	Standard Error	T Statistics	Note
Patient Safety Culture	Reporting Flow chart Perception	0.382	0,067	5.745	H2 accepted
Patient safety culture	Nurse intention to report	0,013	0.076	0.171	H3 rejected
Reporting Flow chart Perception	Nurse intention to report	0.555	0,064	8.604	H4 accepted

2. Indirect Impact Hypothesis Testing

Table 6.

The result of indirect impact hypothesis

Exogenus	Mediation	Endogenous	Indirect Coefficient	Standar d Error	T Statistics	Note
Patient Safety Culture	Reporting Flowchar t Perc	Nurse intention to report	0.382	0,067	5.745	H1 accepte d

	eptio n					

3. Dominant Impact

Table 7.
Dominant Impact

Exogenous	Mediation	Endogenous	Total Coefficient	Note
Patient Safety Culture	-	Reporting Flow chart Perception	0.382	-
Patient Safety Culture	Reporting Flow chart Perception	Nurse Intention to Report	0.255	-
Reporting Flow chart Perception	-	Nurse Intention to Report	0.555	Dominant

Based on data from the table above, the nurse perception variable of Patient Safety Incident reporting flowchart, the most dominant impact towards nurse intention to report patient safety incident is with the value of 0.555 or 55,5%.

Discussion

Patient safety culture in X Hospital Malang obtained moderate value (2.99). There are several dimensions of safety culture that valued weak which are dimensions of communication openness (2,37), staffing (2.47), non-punitive reaction to errors (2.55), management support of patient safety (2.56), Expectations and actions of managers in promoting patient safety (2.57), the perception of patient safety (2,58), organizational learning with continuous improvement (2.59).

Table 8
Dimension of Communication Openness

No.	Question	Answered Value	Note
1	Staff at our uni tis free to speak if witnessing something that negatively affects patient service	3.30	moder ate

2	Staff at our unit can question the decision or action taken by his superior	2.16	weak
3	Staff at our unit is afraid to ask if something that is not right occur	1.65	Very wea k
The tendency of total		**2.37**	**weak**

Dimensions of Communication Openness is still weak, staff are not free to speak if they see something that might give a negative impact to the patient and did not feel free to question to someone with more authority.

Disclosure of such communication include freedom of expression, freedom of asking a fellow nurse / physician regarding actions to be taken, free from fear if they see there is something wrong in the service.

Effective communication is one of the essential strategies for building patient safety culture. Effective communication plays an important role in reducing unwanted adverse event in patient's medical care.

Reporting and compliance toward safety procedures become parameters that are used as benchmarks of the implementation of the effective safety communication including become important to achieve a safe service and safety culture.

Based on the AHRQ report, communication becomes 65% of the main cause of adverse event. Communication should occur in a two-ways pattern, from the leader to the front line personnel and vice versa. Likewise, silent action against errors, should be replaced by openness, honesty about the incident involving patient safety. So it can be judged that the nurses in the unit has yet to have openness in communication among nurses,
physicians, and other health workers.

Openness in communication also involves patient. Patients get an explanation of the actions and events that have occurred. Patients get information about the conditions that will lead to the risk of error. Nurses give motivation to provide any matters relating to patient safety (Nurmalia, 2012). Strategies that can be taken such as by providing access for patients and families to the information of received services.

Provide sufficient time for the patient to communicate with staff and increased patient education related to the safety are some efforts that can be made. SPEAK UP method is the method recommended by JCAHO for effective communication between patients and staff (Cahyono, 2008).

Communication patterns affect the patient safety culture, communication patterns describe mutual trust and openness (communication founded on mutual trust and openness); flow and process of good information process (good information flow and processing) will improve patient safety culture.

Table 9 Dimension of Staffing

Question	**Answered Value**	**Note**
1. Our unit has enough staf to handle the excessive workload	3.07	Moderate
2. Staff in our unit works overtime for the sake of patient safety	2.11	Weak
3. Our unit uses a lot of extra energy in patient safety activities	2.42	Weak
4. We work in crisis mode trying to handle too much too fast	2,32	Weak
The tendency of total	**2.47**	**Weak**

Staffing is still weak means not enough staff to handle the workload resulting in working hours do not fit to provide the best care for patients. This is consistent with the distribution of respondents that staff work more

than 40 hours in a week.

Staff is hard to focus on service while working because many disorders that result in the provision of patient care is not oriented to patient safety. The staff is rush to work in "crisis mode" trying to do too much, too fast.

Excessive workload will cause various effects of the physical and mental fatigue and emotional reactions such as headaches, digestive disorders, neglect, forgetfulness and irritability that are potentially harmful to workers or nurses. (Manuaba, 2000).

The same thing was also delivered by Griffiths et al (2008), which states that the factors that influence the risk of infection in the hospital one of which is a workload that is not in accordance with the available staff. Adverse event may cause several problems such as human resources issues, policies, inadequate procedures and technical failures (AHRQ, 2003). The good human resource management whether in terms of quality and quantity mad prevent the occurrence of patient safety incident.

Based on the above theory, it can be concluded that attention needs to be paid to implement patient safety in hospitals by considering human resources, working hours, workload, shift, working time factors that can result in work stress so the services become ineffective rather than the core issue that needs to be resolved.

The important issue is not who is to blame, but how and why the incident occurred.

In creating a patient safety culture is the incident reporting and feedback system, this condition has not been entrenched in health care institutions due to some factors such as fearness or worriness or even considering that incident is a dishonor that must be covered.

Adequate information will be used as the data for learning process to improve patient safety efforts.

Table 11
Dimension of Management Support to Patient Safety

Question	Answered Value	Note
1. Hospital management create working atmosphere that supports patient safety	3.00	moderate
2. Action taken by hospital management shows that patient safety is top priority	1.17	Very weak
3. Hospital management seems interested in patient safety only when adverse event occurs	3.50	Strong
The total tendency	**2.56**	**Weak**

Table 10
Dimension of non-punitive reaction to errors

Question	Answered Value	Note
1. Our unit staff often feels that if they commit mistake, they will be blamed	2.72	Moderate

2. When our unit reports an incident, what is being discussed is the name of the culprit instead of the Problem	2,67	Moderate
3. Staff worry about the mistakes they make will be recorded in their performance appraisal	2,27	Weak
The total tendency	**2.55**	**Weak**

Non-punitive reaction to errors dimension is still weak. Staff felt that error and incident reports they submitted to and that the errors occurred are recorded in their personnel file.

Accuse, blame, and criticize culture, the mistakes that they have been made became a bad record for their performance appraisal in the past and future. There is concern in themselves that bad record can affect their career path in the hospital. Often the results of the evaluation of PSI are more disadvantaging the involving suspect

Management support to patient safety is still weak. Hospital management has shown that patient safety is a top priority, but has yet to provide a working environment that promotes patient safety.

Hospital staff felt that management seems interested in patient safety only when adverse event occurs, this is confirmed through interviews with KPRS team. KPRS team revealed that we follow-up based on reports received, whereas the reported were just noharm event, adverse event, and sentinel event. And for investigation of potential to harm and near miss events were not as sensational as when adverse event occurs. But in fact the KPRS team did follow-up to all incoming PSI reports. Action taken by hospital management showed that patient safety is the top priority is very weak, it is justified because KPRS team was less intensely carry out actions and socializations, even though the follow-up when PSI occurred was good. KPRS team performed investigation and meeting immediately but not forwarded to all units, only involving units that are given socialization because they attended the meeting.

Based on secondary data evaluation (work program and Annual Budget Plan) , it isobtained that patient safety program is already listed in the Annual Budget Plan but support forfacilities and infrastructure are lacking. In the Annual Budget Plan, support for the facilities and infrastructures that support patient safety has not been budgeted.

Table 12
Dimensions of Expectations & Actions of Manager in Promoting Patient Safety

Question	Answered Value	Note
1. The manager/supervisor in our unit compliments us when seeing a task is finished according to patient safety procedures.	3.65	Strong
2. Managers/supervisors is seriously considering the input from staff to improve patient safety	3.87	Strong
3. If workload is high, the manager/supervisor asks us to work faster even if it means taking shortcuts	1.57	Very weak
4. The manager/supervisor ignore patient safety problems that occur repeatedly in our unit	1.20	Very weak
The total tendency	**2.57**	**Weak**

2. Procedures and systems in our unit are already well in preventing incidents / error	1.69	Very wea k
3. It was because of luck that more serious incident did not happen in our unit	2.23	Weak
4. There are still many patient safety issues in our unit	3.32	moderate
The total tendency	**2.58**	**Weak**

Perceptions of patient safety is still weak. Procedures and systems to prevent errors are not good and still no shortage of patient safety problems. Staff awareness on patient safety culture is not optimal due to the increased number of PSI (averse event and sentinel) it illustrates that the mechanism of defense barrier of the theory of "Swiss Cheese Model" has not run optimally, even some adverse event incidents can actually be prevented, but because of the awareness to prioritize patient safety has not been good, it may cause incident.

Table 14

Dimension of Organizational Learning With Continuous Improvement

Question	Answered Value	Note
1. Our unit was actively conduct activities to improve patient safety	1.99	weak
2. In our unit, the error that occurs is used to make changes in a positive direction	1.79	very weak
3. To improve patient safety, our units evaluate the changes / improvements that have been made	3.98	Strong
The total tendency	**2,59**	**Weak**

Expectations and actions of managers are still considered weak.

Respondents felt that the supervisor / manager in the unit give compliment if seeing a task is carried out according to patient safety procedures, it would be better if it can be developed with further research, to compare between the units, as in the present study, the author did not see which unit gives appreciation in a form of compliment to their staff, it is very positive and can be used as a pilot unit to motivate other units.

Based on the evaluation through interviews and secondary data (form of supervision and performance evaluation of supervisors), lack of information, action and supervision of KPRS team against the unit.

Supervisors have not competent so they are less active in following-up the suggestions from unit. Supervisor rarely give appreciation to the unit when doing the right thing.

Table 13
Dimension of Perceptions of Patient Safety

Organizational leraning with continuous improvement is still weak. Weak organizational learning dimension with the ongoing improvements can be caused by the absence of a continuous evaluation of the unit and KPRS team, no follow-up, no evaluation, changes of innovation are not running, so there is no evaluation of the effectiveness of the changes. Organizational learning will not run optimally when the evaluation and follow-up of occured patient safety incidents are neglected.

The next dimension that is valued moderate is Event Reporting Frequency with the number of (3.23).

Table 15
Dimension of Event Reporting Frequency

Question	Answered Value	Note
1. When an error occurs, but was recognized and corrected prior to exposure to the patient, how often it is reported?	3.27	moderate

Question	Answered Value	Note
1. Our unit never sacrificed patient safety to complete more task	1.65	Very weak
2. When an error occurs, but no potential harm to the patient, how often it is	3.06	moderate

reported?		
3. When an error occurs, and should have injured the patient but they did not, how often it is reported?	3.29	moderate
The total tendency	**3.23**	**moderate**

Based on the event reporting frequency is still weak. In the table above, it can be seen that the tendency of respondents reported PSI is moderated, but the highest rate is found in the report that has been exposed to the patient. No harm event (if something goes wrong, and should harm the patient but apparently not) quite often, followed by reporting near miss event (when an error occurs but it was recognized and corrected prior to exposure to the patient), and lower in the reporting potential to harm event (potentially harmful the patient). This illustrates the nurse intention to report PSI is moderate, but needs to be improved in order to look for solutions to prevent PSI to happen. Because the PSI that occur can cause damage to hospital.

Next is a discussion of the strong patient safety culture dimensions which are cooperation between units (3.93) followed by feedback and communication dimensions (3.84), the dimensions of cooperation within unit (3.80) and information handover and patient transfer (3.42).

Table 16

Dimension of Cooperation Between Units

Question	Answered Value	Note
1. Units in hospitals collaborate well while requiring cooperation among units	3.58	Strong
2. Provide the best service for patients	4.04	Strong
3. In our hospital, one unit doesn't coordinate well with one another	3.63	Strong
4. Often extremely unpleasant to work with staff in other unit.	3.72	Strong
The total tendency	**3.93**	**Strong**

Dimension of cooperation between units is strong. From the table above the highest value is staff feels to provide the best service for patients. To assess the service provided is really good, there must be standards that can be measured as well as someone who assesses or monitors, if what staff do has been consistent and appropriate. If there is no assessment standard, it is concerned that the result is subjective.

Table 17

Dimension of Cooperation Within Unit

1. Staff in our unit support each other	3.96	Strong
2. Our unit has enough staff to handle the excessive workload	3.80	Strong
3. Staff in our unit respect each other	4.03	Strong

4. When the area in our unit is busy, the he busy area in our unit, the other area in our unit will help	3.41	Strong
The tendency of total	**3.8**	**Strong**

Cooperation within unit is already strong. Based on the evaluation through interviews and secondary data (coordination meeting) the cooperation is good. Meetings within the unit and between units run well, they support each other and work together, and have a homogeneous characteristics (young adults with the age of 20- 30 and above).

Table 18

Dimension of Communication and Feedback on Errors

Question	Answered Value	Note
1. Staff in our unit reveice feedback on the changes that are implemented based on an incident report	3.53	Strong
2. Staff in our unit received information about the incident that occurred in the unit	3.80	Strong
3. In our unit, it is discussed how to prevent incidents to not reoccur	4.19	Strong
The total tendency	**3.84**	**Strong**

Communication and Feedback on Errors is strong. Based on the evaluation through interviews and secondary data (PSI meeting minutes), the communication and feedback is quickly carried out. After PSI occured, a meeting is held immediately, no later than 2x24 hours, and the enthusiasm of Professional Care Provider (PPA) in providing input and suggestions is high.

One drawback of health care facilities in the past is the inability to recognize that the causes of failures in the health care facilities can be a way to prevent the risk of failure of any other health care facilities. (Ministry of Health Regulations No. 11 of 2017)

Question	Answered Value	Note

Table 19

Dimension of Information Handover and Patient Transfer

Question	Answered Value	Note
1. When transferring patients from one unit to another, there's always missing information (not delivered)	3.09	moderate
2. Important information about patient care is often wrong during shift change	3.37	moderate

3. Problems always arise during information exchange between units in hospital	3.38	moderate
4. The shift change is a problem for patients	3.83	Strong
The total tendency	**3.42**	**Strong**

Information handover and transition is strong, based on evaluation through interviews and secondary data (medical records) goes well, this is evidenced by the handover facility and transition use the checklist form so all information is addressed well during handover and patient transfer.

Out of the 12 dimensions, the most representing patient safety dimension is the event reporting frequency (83%).

The next variable is the variable perception of PSI Reporting Flowchart that obtained moderate value (3.05). Out of the eight question items that representing 4 steps of PSI Reporting in the level of unit staff, it is found that responsdents are still show the lack of knowledge and understanding in distinguishing types of incidents, filling out reports, and performing grading, but is good enough in terms of identifying incidents.

Indicator that is the most representing nurse intention to report incident is when respondents are faced with the situation of adverse event (80%).

The last variable is the nurse intention to obtain moderate value (3.01). Out of the 10 items of questions representing 5 types of patient safety incidents namely potential to harm, near miss, no harm, adverse event and sentinel events obtain good value. Their wish to report adverse event and sentinel is high while to report potential to harm and no harm is low. This shows that their high intention to report is only for type of incidents that give real impact to patients so the possibility of underreporting or hidden incident report become high.

Conclusion and suggestion

Patient safety culture has positive and Patient safety culture has positive and significant effect on the perception of Patient Safety Incident reporting flowchart in X Hospital Malang. This means the better patient safety culture the better the perception of nurses on patient safety incident reporting workflow and patient safety culture contributes to the perception of nurses on safety incident reporting lines by 14.6% (R square).

Perception of Patient Safety Incident reporting flowchart has positive and significant effect on the nurse intention to report Patient Safety Incident in X Hospital Malang. This means the more and better perception of nurses on patient safety incident reporting flowchart, the better their intention to report patient safety incidents.

Patient safety culture has possivite but not significant effect on the desire of the nurse intention to report Patient Safety Incident in X Hospital Malang. This means better patient safety culture, the more likely their intention to be better to report patient safety incident, even though not significant and the patient safety culture contributes to the nurse intention to report patient safety incidents reached 31.4% (R Square).

Suggestions from authors, because variable perception of nurses on patient safety incident reporting flowchart has the most dominant influence on the nurse intention to report patient safety incidents with a value of 55.5% and most representing variable of nurse perception on the PSI Reporting Flowchart is the ability to fill out report as much as 91% so hospital must evaluate the incident reporting in simpler and safer for the reporting by making e-reporting using google form platform. Where the reporting doesn't have to meet face to face to report the incident, when the staff found PSI, staff will only need to open the reporting links that have been made by KPRS team and only to report it. So it is expected that no blaming, no naming, no shaming culture can

significant effect on the nurse intention to report Patient Safety Incident with the perceptions of Patient Safety Incident Reporting Flowchart as the intervening variable in X Hospital Malang, This shows that the culture of patient safety must be improved so that the nurse intention to report PSI will also increase through the perception of PSI Reporting Flowchart, so that a good reporting system and systematic followed up to find solutions to minimize risks and prevent the onset of the same events recur.

be formed slowly.

Learning from mistake culture and not blaming the staff who made the mistake must be shown by the leadership to strengthen Hospital Patient Safety Team (TKPRS) as the organizer of patient safety.

KPRS team also has to perform supervision of the incident reporting flowchart mainly in filling out because it is a variable that contributes to the nurse intention. So it will increase the willingness of nurses in reporting all types of incidents, especially the condition of the potential to harm, near miss events the reported incident will help in obtaining valid data to determine the detail cause of the incident and its prevention.

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