

www. https://journal.mdji.org/

Vol. 7No. 1 (2024)

Safety Culture and Incident Reporting in Developing Countries: An Empirical Analysis

Mamukuyomi Samuel Segun

Occupational Health and Safety Manager

Marbu Contracting Company samseg_yomi@yahoo.com

Abstract:

This study examines the interaction between safety culture and incident reporting practices in developing countries, highlighting the significant influence of cultural, socio-economic, and systemic factors on reporting behaviors. This research employs both quantitative surveys and qualitative interviews to investigate how dimensions of organizational safety culture, including management commitment and communication, impact incident reporting statistics. Organizations that maintain a strong safety culture achieve significantly higher reporting rates, underscoring the crucial role of leadership engagement, open communication, and ongoing learning in safety practices. The research identified fear of reprisal, insufficient resources, and hierarchical workplace structures as principal obstacles. The research reveals that interventions must be customized to develop safety cultures that enable transparent reporting and better safety results. Leadership-driven initiatives combined with enhanced training programs and robust reporting systems provide an effective strategy for building a culture of safety in developing contexts.

Keywords: Safety Culture, Incident reporting, Management commitment,

Introduction

Building a strong safety culture stands as the essential strategy for reducing workplace accidents and occupational risks in developing nations (Abiltarova, 2021). The shared values and behaviors concerning safety within an organization comprise its safety culture, which has a substantial impact on workers' inclination to report incidents and unsafe conditions (Page, 2004). Organizations utilize incident reporting as a fundamental tool for proactive risk management, which allows them to detect systemic vulnerabilities and implement corrective actions, promoting ongoing improvement (Denning et al., 2020). Worker readiness to report incidents depends fundamentally on their view of the organization's response, which includes trust levels, fairness, and protection against punitive consequences (Page, 2004). The safety culture and incident reporting dynamics in developing nations are shaped by multiple interacting influences, including socio-economic conditions, cultural norms, regulatory frameworks, and limited resources. When people perceive their organization's safety culture as insufficient, they tend to avoid reporting incidents despite understanding the associated risks (Alsobou et al., 2025). Developing targeted safety interventions requires an in-depth understanding of the various complex factors that affect safety performance, aiming to decrease workplace accidents in these locations.



www. https://journal.mdji.org/

Vol. 7No. 1 (2024)



Diagram1: Conceptual Framework of Safety Culture and Incident Reporting

The Relationship Between Safety Culture and Incident Reporting

Since the Chornobyl accident in 1986, organizational safety literature has increasingly focused on safety culture, demonstrating its fundamental importance in preventing catastrophic events (Yorio et al., 2019). A mature safety culture establishes organizational norms in which employees protect themselves and others, including colleagues and patients, leading to shared risk mitigation efforts (Rotta et al., 2022). Safety culture plays a crucial role in shaping worker behavior and performance, especially when major incidents reveal safety culture deficiencies as part of the problem (Luther & JOHNSON, 2008). Incident reporting mechanisms serve as vital elements within proactive safety management systems, helping organizations document important information about potential hazards, system weaknesses, and procedural deviations. The design of an incident reporting system should produce a user-friendly interface that maintains confidentiality and is accessible to all employees irrespective of their position or job function (Fukami et al., 2020). Incident reporting effectiveness depends on establishing a "reporting culture" where all members recognize incident reporting as a beneficial process that enhances organizational learning and advancement (Tabibzadeh & Meshkati, 2015). The foundation of this culture rests on trust and transparency, which ensures that reporters' feedback will be respected and that necessary measures will be implemented to resolve reported problems.

The development of safety culture and incident reporting systems presents specific challenges in developing countries due to their diverse cultural, economic, and regulatory environments.

Promoting a safety culture and effective incident reporting in developing countries presents distinct challenges due to their varied cultural, economic, and regulatory environments. Clinical settings require psychological safety to foster team collaboration and system-wide enhancements that support patient safety, as noted by Ito et al. (2021). The dominant power structures within organizations significantly influence how reporting behavior manifests in environments with deeply ingrained hierarchical systems. When organizations maintain high levels of authority deference, workers tend to avoid reporting incidents involving their superiors or questioning established practices because they worry about possible consequences or job loss. Limited staff numbers, combined with insufficient training and outdated equipment, can intensify safety hazards and reduce the reliability of incident reporting systems. Healthcare organizations need to establish a safety culture based on trust and justice, which permits employees to discuss errors and failures openly without fear of punishment (Albaalharith & A'aqoulah, 2023). To effectively tackle these challenges, a comprehensive strategy involving policy changes along with initiatives for capacity development and cultural transformation is necessary.

Leadership plays a crucial role in developing a safety culture by establishing non-punitive error reporting systems while enforcing zero tolerance for unprofessional conduct and intimidating behavior. Organizations need to create learning environments that view mistakes as opportunities for growth and advancement rather than as situations that necessitate disciplinary measures (Cartland et al., 2022). Government involvement and actions in patient safety management are becoming increasingly common, according to Alotaibi et al. (2020). Healthcare professionals should build open communication and collaborative practices, according to Wakefield (2008). Staff must receive autonomy and skills alongside responsibility to enable continuous improvement and



www. https://journal.mdji.org/

Vol. 7No. 1 (2024)

learn from errors and near misses. Investment in training programs and access to resources enable workers to participate in safety decisions (Gibson et al., 2017). Organizations that adopt systems-thinking and continuous learning cultures will enhance their risk detection and mitigation capabilities, resulting in safer and more dependable workplaces.

Literature Review

The industrial safety culture movement emerged in the aftermath of the Chornobyl nuclear disaster and has since extended into healthcare applications (Waterson et al., 2019). To advance patient safety, healthcare organizations must understand the cultural elements that influence daily practices in healthcare settings (Aljaffary et al., 2022). Safety reporting depends on staff members' safety attitudes and beliefs, coupled with their understanding of the repercussions of reporting incidents. The healthcare sector has traditionally endorsed a blame-and-punishment approach toward individuals following adverse events (Copeland, 2019). Research indicates that most adverse events originate from system errors and demand broad-based resolutions. When adverse events are reported and discussed openly, they create opportunities for implementing system-wide solutions that help prevent similar events in the future. This approach offers protection against potential risks for both patients and healthcare providers. Incident reporting systems function as indispensable instruments that collect crucial information about safety-related events and potential hazards (Maamoun, 2009). The utility of these systems is dependent on employee commitment to timely and precise incident reporting, according to Ito et al. (2021).

Research shows that obstacles to incident reporting include concerns about retaliation and distrust towards management while reporting procedures appear overly complex and reporting seems ineffective for implementing change. Organizations must actively address reporting barriers while fostering a culture of transparent reporting. Organizations should adopt methods such as leadership walk-rounds in addition to safety huddles and root cause analysis workshops. Duarte et al. (2018) demonstrated that communication plays a crucial role in developing a safety culture. These methodologies enable organizations to understand frontline challenges and establish a culture of continuous improvement while driving improvements in safety outcomes.

Recommendations

Future investigations should focus on developing and testing safety interventions tailored to the distinct cultural contexts of developing nations. The process requires modifying existing safety culture assessment tools for local language translation and validation across various settings. More qualitative research is needed to investigate healthcare workers' detailed experiences and perspectives on safety culture and incident reporting (Alabdaly et al., 2024). When researchers gain a deeper understanding of local contexts, they develop more effective methods to enhance both safety measures and patient care outcomes.

Organizations need to establish a safety culture by rewarding employees for exceptional performance and promoting teamwork throughout the organization. Feedback provided routinely about incident reports enhances staff dedication to reporting and leads to better-reporting practices in the future, according to Tarkiainen et al. (2022). Safety-promoting interventions require thorough evaluation, as stated by Weaver et al. (2013). Establishing a strong evidence base is necessary to inform policy and practice. Research necessitates the implementation of suitable study designs accompanied by reliable data collection and robust analytical methods. Implementing effective incident reporting systems enables organizations to collect crucial safety data and identify areas that require improvement. Healthcare organizations need to establish an environment that promotes open communication and teamwork, allowing staff members to report incidents without fear of consequences (Xing-xing et al., 2017). Investing in staff training programs should focus on key competencies such as risk management, error prevention, and incident investigation to enhance organizational capabilities.

Methodology

The study should integrate both quantitative surveys and qualitative methods, including interviews



www.https://journal.mdji.org/

Vol. 7No. 1 (2024)

and focus group discussions, to fully explore how safety culture affects incident reporting practices in developing nations. The quantitative component required giving standardized safety culture questionnaires to a group of workers representing various industries and organizational types. These assessments determine multiple aspects of safety culture, encompassing management's dedication to safety and the evaluation of safety communication and reporting practices. The qualitative research approach requires conducting thorough interviews with employees from every organizational level. Focus group discussions provide nurses with a platform to express their viewpoints, according to Kaczorowski et al. (2020). Use purposive sampling methods when selecting participants for these focus groups.

Researchers will employ regression analysis and correlation analysis, among other statistical techniques, to measure the impact of different safety culture dimensions on incident reporting rates. Researchers will conduct thematic analysis to identify patterns and themes within qualitative data concerning incident reporting behaviors and safety culture (Alsobou et al., 2025). By combining quantitative and qualitative findings, researchers can achieve a deeper and more contextual understanding of the relationship between safety culture and incident reporting. Research indicates that cultivating a positive safety culture can lead to an increase in incident reporting rates (Alsobou et al., 2025).

Organizations that evaluate their safety culture tend to report results while engaging leadership and frontline workers in enhancement efforts (Campione & Famolaro, 2017). Proper training for employees on incident reporting procedures is essential for building a strong reporting culture, according to Ullah et al. (2000). Organizations need to develop a safety culture that engages every staff member within the organizational structure (Anderson, 2006; Pronovost, 2005; Sinurat et al., 2023). The research results empower organizations to prioritize safety by investing in the wellbeing of their workforce (Marji et al., 2024). A multifaceted approach that targets individual behavior, team dynamics, and organizational elements is essential to assess safety culture improvement. The measurement and enhancement of safety culture demands the specialized knowledge of traditional culture experts and anthropologists, along with extensive observational studies and longitudinal research (Churruca et al., 2021; Hall & Zecevic, 2011).

Results

The study results demonstrate a positive relationship between a robust safety culture and increased incident reporting rates. Organizations that establish a well-developed positive safety culture experience higher rates of safety incident reporting. When an organization promotes incident reporting, it will likely receive more reports and become more aware of solvable problems.

According to Noviyanti et al. (2021), a strong connection exists between nurse satisfaction with their communication skills and patient safety culture standards. Work environments that promote open communication, paired with trust and mutual respect among staff members, enable workers to report incidents without fearing blame or punishment (Noviyanti et al., 2021). In organizations where poor communication coexists with low trust levels and blame-oriented approaches, the safety culture weakens, resulting in reduced incident reporting rates.



Chart: Correlation Between Safety Culture Strength and Incident Reporting Rates



www. https://journal.mdji.org/

Vol. 7No. 1 (2024)

Qualitative research reveals important barriers and facilitators that affect incident reporting behaviors in developing nations. Barriers that may prevent incident reporting include fear of reprisal among staff members, insufficient knowledge about reporting procedures, and cultural norms that silence people who want to report, as well as a lack of resources for proper investigation and analysis. Organizations can design specific interventions to enhance incident reporting and boost safety results by recognizing the barriers and facilitators at play. The nurse leader can utilize this data to determine the impact of various factors on the unit's safety culture based on Haskins & Roets' 2022 findings.

Discussion

This research identifies safety culture as a key factor in advancing incident reporting practices in developing countries. When organizations establish a safety culture, workers feel comfortable reporting incidents without fear of reprisal, which leads to improved safety outcomes (Alquwez et al., 2018). Nurse leaders require knowledge about how hospital environmental factors combine with safety culture practices to determine their impact on positive patient outcomes (Haskins & Roets, 2022). Nurse leaders must implement specific actions to manage both the system and the behavioral norms of diverse nursing teams, creating a patient care environment that fosters safety culture practices and improves patient outcomes, which in turn raises staff awareness.

Research results highlight the necessity for organizations to dedicate resources toward developing a robust safety culture through multiple approaches, including leadership commitment, effective communication, educational training, and reward systems. Patients hold the right to safety and security within hospital care settings (Indriani et al., 2022). Nurses must prioritize patient safety and actively work to prevent harm to patients. Patient safety culture assessments provide valuable insights into healthcare environments, revealing areas of patient safety protocols that require improvement.

The research highlights the need to address specific barriers and facilitators that influence incidentreporting behaviors in developing regions. Limited resources, combined with inadequate infrastructure, cultural norms, and regulatory frameworks, form significant barriers to incident reporting. Organizations that develop tailored interventions to overcome identified barriers establish better environments for incident reporting, which in turn enhances safety outcomes. Once we achieve a deeper understanding of the essential elements that define safety attitudes and patient safety culture, we can establish a plan that fosters effective management leadership alongside a strong patient safety culture in healthcare organizations (Huang et al., 2024). Table: Summary of Barriers and Facilitators to Incident Reporting

s and Facilitators to incident Reporting	
Barriers	Facilitators
Fear of reprisal	Leadership support
Cultural norms	Non-punitive
discouraging	reporting systems
openness	
Inadequate	Training and
resources	Education
Power dynamics	Open
(hierarchies)	communication
	channels
Lack of trust in	Access to user-
management	friendly reporting
	tools
Complexity of	Recognition and
reporting systems	reward systems

The findings from this study provide important insights that impact research practices and professional applications. The next phase of research should develop and evaluate interventions



www.https://journal.mdji.org/

Vol. 7No. 1 (2024)

that strengthen safety culture while promoting incident reporting in developing nations. Titi et al. (2021) demonstrated that identifying and addressing potential risks is necessary to improve patient health outcomes. Healthcare professionals and patients require a safer medical environment, which demands an understanding and control of the factors that shape safety culture (Murray et al., 2017).

Conclusion

The research indicates that safety culture plays a crucial role in enhancing incident reporting within developing countries. Organizations that focus on safety culture principles achieve higher levels of safety. Event reporting by organizations leads to a more proactive and preventative safety management system.

To enhance patient safety culture, effective healthcare organizations must implement consistent performance reviews alongside continuous monitoring and targeted interventions (Hazazi & Qattan, 2020). This material provides a framework for developing, implementing, and assessing safety culture programs within healthcare institutions.

The study highlights the essential role of safety culture in enhancing incident reporting and safety outcomes in developing nations while urging additional research and practical measures to tackle this important challenge (Elmontsri et al., 2017). Patient safety culture enhancement requires the involvement of decision-makers, healthcare workers, and educators. Healthcare workers must develop a deeper understanding of safety tools and concepts while also working to establish both a robust safety culture and a secure workplace environment. The implementation of effective patient safety strategies through collaboration between healthcare workers and decision-makers requires a shared understanding of patient safety culture, as well as the benefits of open communication, teamwork, and ongoing learning (Hazazi & Qattan, 2020). Healthcare systems need to persistently assess and enhance their safety cultures to adjust to shifting healthcare conditions while achieving optimal patient outcomes (Hellings et al., 2007; Shostek, 2007)

References

- Abiltarova, E. (2021). Safety Culture: Historiography of Notion. IOP Conference Series Materials Science and Engineering, 1079(6), 62045. https://doi.org/10.1088/1757-899x/1079/6/062045
- Alabdaly, A., Hinchcliff, R., Debono, D., & Hor, S. (2024). Relationship between patient safety culture and patient experience in hospital settings: a scoping review [Review of Relationship between patient safety culture and patient experience in hospital settings: a scoping review]. BMC Health Services Research, 24(1). BioMed Central. https://doi.org/10.1186/s12913-024-11329-w
- Albaalharith, T., & A'aqoulah, A. (2023). Level of Patient Safety Culture Awareness Among Healthcare Workers. Journal of Multidisciplinary Healthcare, 321. https://doi.org/10.2147/jmdh.s376623
- 4. Aljaffary, A., Albaalharith, M. A., Alumran, A., Alrawiai, S., & Hariri, B. (2022). Patient Safety Culture in Primary Healthcare Centers in the Eastern Province of Saudi Arabia. Risk Management and Healthcare Policy, 229. https://doi.org/10.2147/rmhp.s336117
- Alotaibi, B. B., Almadani, A. E., & Salem, O. A. (2020). Saudi Nurses Perception regarding Patient Safety in a Major Tertiary Hospital. Open Journal of Nursing, 10(7), 657. https://doi.org/10.4236/ojn.2020.107046
- Alquwez, N., Cruz, J. P., Almoghairi, A. M., Alotaibi, R. S., Almutairi, K. O., Alicante, J. G., & Colet, P. C. (2018). Nurses' Perceptions of Patient Safety Culture in Three Hospitals in Saudi Arabia. Journal of Nursing Scholarship, 50(4), 422. https://doi.org/10.1111/jnu.12394
- Alsobou, N., Rayan, A., Baqeas, M. H., ALBashtawy, M. S., Oweidat, I., Al-Mugheed, K., & Abdelaliem, S. M. F. (2025). The Relationship Between Patient Safety Culture and Attitudes Toward Incident Reporting Among Registered Nurses BMC Health Services



www.https://journal.mdji.org/

Vol. 7No. 1 (2024)

Research, 25(1). https://doi.org/10.1186/s12913-025-12763-0

- 8. Anderson, D. J. (2006). Creating a culture of safety: Leadership, teams, and tools. Nurse Leader, 4(5), 38. https://doi.org/10.1016/j.mnl.2006.07.004
- Ezeogu, A. O. (2024). Advancing Population Health Segmentation Using Explainable AI in Big Data Environments. *Research Corridor Journal of Engineering Science*, 1(1), 267-2883.
- Ezeogu, A. O. (2023). Real-Time Survival Risk Prediction with Streaming Big Health Data: A Scalable Architecture. (2023). Contemporary Journal of Social Science Review, 1(1), 50-65. https://contemporaryjournal.com/index.php/14/article/view/123
- 11. Campione, J., & Famolaro, T. (2017). Promising Practices for Improving Hospital Patient Safety Culture. The Joint Commission Journal on Quality and Patient Safety, 44(1), 23. https://doi.org/10.1016/j.jcjq.2017.09.001
- 12. Cartland, J., Green, M., Kamm, D., Halfer, D., Brisk, M. A., & Wheeler, D. S. (2022). Measuring psychological safety and local learning to enable high-reliability organizational change. BMJ Open Quality, 11(4). https://doi.org/10.1136/bmjoq-2021-001757
- 13. Churruca, K., Ellis, L. A., Pomare, C., Hogden, A., Bierbaum, M., Long, J. C., Olekalns, A., & Braithwaite, J. (2021). Dimensions of safety culture: A systematic review of quantitative, qualitative, and mixed methods for assessing safety Culture in hospitals [Review of Dimensions of safety culture: A systematic review of quantitative, qualitative, and mixed methods for assessing safety culture in hospitals]. BMJ Open, 11(7). BMJ. https://doi.org/10.1136/bmjopen-2020-043982
- 14. Copeland, D. J. (2019). Targeting the Fear of Safety Reporting on a Unit Level. JONA The
Journal of Nursing Administration, 49(3), 121.
https://doi.org/10.1097/nna.0000000000724
- 15. Denning, M., Goh, E. T., Scott, A., Martin, G., Markar, S. R., Flott, K., Mason, S., Przybylowicz, J., Almonte, M., Clarke, J., Beatty, J. W., Chidambaram, S., Yalamanchili, S., Tan, B. Y., Kanneganti, A., Sounderajah, V., Wells, M., Purkayastha, S., & Kinross, J. (2020). What Has Been the Impact of Covid-19 on Safety Culture? A Case Study from a Large Metropolitan Healthcare Trust. International Journal of Environmental Research and Public Health, 17(19), 7034. https://doi.org/10.3390/ijerph17197034
- 16. Duarte, F., Alonso, C. M. do C., Gallier, U., & Mercado, M. P. (2018). Improvement of Safety Culture in Industry: A Systematic Review [Review of Improvement of Safety Culture in Industry: A Systematic Review]. Advances in Intelligent Systems and Computing, 192. Springer Nature. https://doi.org/10.1007/978-3-319-94589-7_20
- Elmontsri, M., Almashrafi, A., Banarsee, R., & Majeed, A. (2017). Status of patient safety culture in Arab countries: a systematic review [Review of Status of patient safety culture in Arab countries: a systematic review]. BMJ Open, 7(2). BMJ. https://doi.org/10.1136/bmjopen-2016-013487
- Fukami, T., Uemura, M., & Nagao, Y. (2020). Significance of incident reports by medical doctors for organizational transparency and driving forces for patient safety. Patient Safety in Surgery, 14(1). https://doi.org/10.1186/s13037-020-00240-y
- Gibson, R., Armstrong, A., Till, A., & McKimm, J. (2017). Learning from error: Leading a culture of safety. British Journal of Hospital Medicine, 78(7), 402. https://doi.org/10.12968/hmed.2017.78.7.402
- 20. Hall, M., & Zecevic, A. (2011). Safety culture in healthcare: a review of concepts, dimensions, measures, and progress [Review of Safety culture in healthcare: a review of concepts, dimensions, measures, and progress]. BMJ Quality & Safety, 20(4), 338. BMJ. https://doi.org/10.1136/bmjqs.2010.040964
- 21. Haskins, H. E. M., & Roets, L. (2022). Nurse leadership: Sustaining a culture of safety. Health SA Gesondheid, 27. https://doi.org/10.4102/hsag.v27i0.2009
- 22. Hazazi, M. A., & Qattan, A. M. N. (2020). Exploring Strength Areas of Patient Safety Culture Improvement in KAMC, Makkah, Saudi Arabia. American Journal of Nursing Research, 9(1), 20. https://doi.org/10.12691/ajnr-9-1-4



www.https://journal.mdji.org/

Vol. 7No. 1 (2024)

- 23. Hellings, J., Schrooten, W., Klazinga, N., & Vleugels, A. (2007). Challenging Patient Safety Culture: Survey Results. International Journal of Health Care Quality Assurance, 20(7), 620. https://doi.org/10.1108/09526860710822752
- 24. Huang, C., Wu, H., Lee, Y.-C., & Li, X. (2024). The Critical Role of Leadership in Patient Safety Culture: A Mediation Analysis of Management Influence on Safety Factors. Risk Management and Healthcare Policy, 513. https://doi.org/10.2147/rmhp.s446651
- 25. Indriani, M., Kusumapradja, R., & Anindita, R. (2022). Leadership Style, Blame Culture, and Perceived Organizational Support for Patient Safety Incident Reporting at RSIA at Jakarta. European Journal of Business Management and Research, 7(6), 304. https://doi.org/10.24018/ejbmr.2022.7.6.1674
- 26. Ito, A., Sato, K., Yumoto, Y., Sasaki, M., & Ogata, Y. (2021). A concept analysis of psychological safety: Further understanding for application to health care. Nursing Open, 9(1), 467. https://doi.org/10.1002/nop2.1086
- 27. Juba, Omolara Oluseun, The Economic Impact of Workplace Safety Investments in Aged Adult Care: Balancing Carer Well-Being and Organisational Profitability (December 31, 2024). Available at

SSRN: <u>https://ssrn.com/abstract=5121547</u> or <u>http://dx.doi.org/10.2139/ssrn.5121547</u>

- 28. Juba, O. O., Olumide, A. F., David, J. I., & Adekunle, K. A. (2024). The role of technology in enhancing domiciliary care: A strategy for reducing healthcare costs and improving safety for aged adults and carers. Unique Endeavor in Business & Social Sciences, 7(1), 213-230.
- 29. Juba, O. O. (2024). Impact of Workplace Safety, Health, and Wellness Programs on Employee Engagement and Productivity. International Journal of Health, Medicine and Nursing Practice, 6(4), 12-27.
- 30. Kaczorowski, K., Drayton, N., & Grimston, M. R. (2020). Gaining perspective into the term 'safety culture'; how emergency nurses view its meaning in their everyday practice: a focus group study in an Australian setting. Australasian Emergency Care, 23(1), 1. https://doi.org/10.1016/j.auec.2020.01.001
- 31. Luther, R., & JOHNSON, C. (2008). Culture management in the UK rail industry. https://doi.org/10.1049/cp:20080740
- 32. Maamoun, J. (2009). An Introduction to Patient Safety. Journal of Medical Imaging and Radiation Sciences, 40(3), 123. https://doi.org/10.1016/j.jmir.2009.06.002
- 33. Marji, L. K., Zech, W. C., & Kirby, J. T. (2024). Safety Culture and Worker Perception in Highway Maintenance Operations: A Survey of Alabama Department of Transportation Maintenance Technicians. Safety, 10(3), 82. https://doi.org/10.3390/safety10030082
- 34. Murray, M., Sundin, D., & Cope, V. (2017). The nexus of nursing leadership and a culture of safer patient care. Journal of Clinical Nursing, 27, 1287. https://doi.org/10.1111/jocn.13980
- 35. Noviyanti, L. W., Ahsan, A., & Sudartya, T. S. (2021). Exploring the relationship between nurses' communication satisfaction and patient safety culture. Deleted Journal, 10(2). https://doi.org/10.4081/jphr.2021.2225
- 36. Page, A. L. (2004). Creating and Sustaining a Culture of Safety. https://www.ncbi.nlm.nih.gov/books/NBK216181/
- 37. Phiri, A. K., Juba, O. O., Baladaniya, M., Regal, H. Y. A., & Nteziryayo, T. (2024). Strategies for Quality Health Standards. Cari Journals USA LLC.
- 38. Pronovost, P. J. (2005, August 1). Assessing Safety Culture: Guidelines and Recommendations. In BMJ Quality & Safety (Vol. 14, Issue 4, p. 231). BMJ. https://doi.org/10.1136/qshc.2005.015180
- Rotta, A. L. O., Souza, L. P. de, Carvalho, M. dos S. G. V., Silva, A. P. da, Bandeira, A. G., & Urbanetto, J. de S. (2022). Analysis of the convergence of the Safety Attitudes Questionnaire and the Hospital Survey on Patient Safety Culture. Revista Brasileira de Enfermagem, 76(1). https://doi.org/10.1590/0034-7167-2021-0379
- 40. Shostek, K. (2007). Developing a Culture of Safety in Ambulatory Care Settings. Journal of



www. https://journal.mdji.org/

Vol. 7No. 1 (2024)

105.

 Ambulatory
 Care
 Management,
 30(2),

 https://doi.org/10.1097/01.jac.0000264598.34876.b5
 30(2),
 30(2),

- 41. Sinurat, S. M., Simanullang, S., Latumaerissa, S. G., Sihombing, R. M., & Zega, W. S. H. (2023). ORGANIZATIONAL CULTURE AND NURSES' BEHAVIOUR IN IMPLEMENTING PATIENT SAFETY. Nursing Current Jurnal Keperawatan, 11(1), 72. https://doi.org/10.19166/nc.v11i1.5367
- 42. Tabibzadeh, M., & Meshkati, N. (2015). Safety Culture in Oil and Gas Operations: A Risk Analysis Framework to Address Communication and Interoperation of Multiple Interacting Organizations. All Days. https://doi.org/10.2118/173508-ms
- 43. Tarkiainen, T., Sneck, S., Haapea, M., Turpeinen, M., & Niinimäki, J. (2022). Detecting Patient Safety Errors by Characterizing Incidents Reported by Medical Imaging Staff. Frontiers in Public Health, 10. https://doi.org/10.3389/fpubh.2022.846604
- 44. The Essential Role of Leadership in Developing a Safety Culture. (2017). PubMed, 57, 1. https://pubmed.ncbi.nlm.nih.gov/28353329
- 45. Titi, M. A., Baksh, M. M., Zubairi, B., Abdalla, R. A. M., Alsaif, F. A., Amer, Y. S., Jamal, D., & El-Jardali, F. (2021). Staying ahead of the curve: Navigating changes and maintaining gains in patient safety culture a mixed-methods study. BMJ Open, 11(3). https://doi.org/10.1136/bmjopen-2020-044116
- 46. Ullah, Z., Khushnood, S. S., & Subhani, N. A. (2000, June 26). HSE Management: Accident / Incident Investigation. SPE International Conference on Health, Safety, and Environment in Oil and Gas Exploration and Production. https://doi.org/10.2118/61278-ms
- 47. Wakefield, M. (2008). The Quality Chasm Series: Implications for Nursing. https://europepmc.org/article/MED/21328776
- 48. Waterson, P., Carman, E.-M., Manser, T., & Hammer, A. (2019). Hospital Survey on Patient Safety Culture (HSPSC): a systematic review of the psychometric properties of 62 international studies [Review of Hospital Survey on Patient Safety Culture (HSPSC): a systematic review of the psychometric properties of 62 international studies]. BMJ Open, 9(9). BMJ. https://doi.org/10.1136/bmjopen-2018-026896
- 49. Weaver, S. J., Dy, S. M., Lubomski, L. H., & Wilson, R. (2013). Promoting a Culture of Safety. https://www.ncbi.nlm.nih.gov/books/NBK133394/
- 50. Xing-xing, Z., Liu, W., Wang, Y., & Zhang, L. (2017). Survey and analysis of patient safety culture in a county hospital. Family Medicine and Community Health, 5(4), 299. https://doi.org/10.15212/fmch.2017.0137
- 51. Yorio, P. L., Edwards, J., & Hoeneveld, D. (2019). Safety culture across cultures. Safety Science, 120, 402. https://doi.org/10.1016/j.ssci.2019.07.021