



Analysis of patient safety incident reporting system by health officials at Prof. Dr. Muhammad Ildrem psychiatric hospital Medan

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ARTICLE INFO

Article history:

Received 19 March 2023
Accepted 25 June 2023
Published 20 July 2023

Keyword:

Reporting system
Patient safety incidents
Health workers

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DOI: 10.30604/jika.v8i2.2225
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ABSTRACT

Patient safety is a variable for measuring and evaluating the quality of health services which aims to avoid incidents and reduce the number of unexpected events (KTD). There are many incidents in various hospitals in Indonesia, but the number of recorded cases is still small and generally because not all incidents are reported. Prof. Dr. Muhammad Ildrem Medan Mental Hospital as the research location is known to have incidents that occurred in patients but were not reported properly. This study aims to determine and analyze what factors influence the implementation of patient safety incident reporting by the health dragon officer at the Prof. Dr. Muhammad Ildrem Mental Hospital Medan. This research is a quantitative study with a cross sectional survey design. The population is all health workers (20 doctors and 162 nurses) and all of them are sampled. Data collection techniques through distributing questionnaires and documentation techniques. The analytical method uses univariate, bivariate and multivariate analysis using multiple linear regression equations. The results showed that there was an influence of knowledge, feedback and organization/management on the reporting of patient safety incidents at the Prof. Dr. Muhammad Ildrem Mental Hospital Medan with the dominant factor being feedback. There is no influence of fear factor, flow/reporting process and work environment on patient safety incident reporting at Prof. Dr. Muhammad Ildrem Mental Hospital Medan. Hospital management is advised to provide feedback as quickly and accurately as possible and patient safety incident reporting data is available in each room unit, to make it easier to see the number of incidents that have occurred and the stages of their resolution.

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INTRODUCTION

One indicator of hospital services that is very important is the implementation of patient safety programs. In fact, there are still many Patient Safety Incidents (IKP) found in various hospitals. The National Patient Safety Agency (2017) reports Patient Safety Incidents (IKP) in England (2016), namely 1,879,922 cases. The Ministry of Health (MOH) also reports that the IKP figure in Malaysia (2013) is 2,769 cases. The largest Indonesian state in DKI Jakarta 37.9%; Central Java 15.9%; DIY 13.8%; East Java 11.7%; South Sumatra 6.9%; West Java 2.8%; Bali 1.4%; Aceh 10.7%; and South Sulawesi 0.7% (Hospital Patient Safety Committee, 2015). Patient safety incident reports based on 14.4% Unexpected Events (KTD) and 18.5% Nearly Painful Events (KNC). Causative factors include

clinical procedures 9.3%; and patients fell 5.15% (Mudayana et al, 2019).

In general, the IKP is low in Indonesia because not all are reported. Incidents are not recorded and even escape the attention of health workers and only incidents that are discovered incidentally are reported. Lestari et al (2019) emphasized that IKP reporting can help find and solve problem solving as learning.

According to the Hospital Patient Safety Committee (KKPRS) (2015), several factors affect the low number of incident reports, namely: 1) Incident reporting is still perceived as a nurse's job; 2) Incidents that occur are often hidden (underreport); 3) The existence of a culture of blame (blame culture) is the cause of delays in reporting incidents; 4) Lack of leadership commitment; 5) Lack of outreach and

training; 6) There is no reward from the hospital for reporting; and 7) High workload. This is a challenge for all parties and the government and health facilities are responsible for ensuring that the reporting system can be implemented properly (KKPRS, 2015).

On the other hand, the problem that often occurs is ineffective reporting systems, especially if health workers do not understand the reporting process due to lack of policies, lack of record systems, lack of standards for reporting and lack of clear definitions of reported errors. Reporting systems are in the form of detailed documents and long forms or are impractical. In addition, they did not have enough time to report or even forgot to report some medication errors (Astuti, 2021).

Several previous studies have explained patient safety culture related to the frequency of reporting IKP that has been carried out, especially incidents that do not have the potential for injury when reporting is inappropriate, perceptions of patient safety at the level of patient safety, the number of incident reporting has been carried out well in Yogyakarta City Hospital (Hastuti et al, 2020). Incident reporting has been carried out according to the flow set by the private hospital in Kudus because guidelines are available. Reporting is carried out by officers who first find incidents and make reports within 2x24 hours online using the Sinden application (Lestari et al (2019)).

While Dewi (2018) revealed that IKP reporting for obstetric and gynecology cases at a private public hospital in Yogyakarta has gone well. The influencing factors are knowledge, self-awareness, empathy, and facilities. Inhibiting factors are lack of socialization, shame, fear, and the addition of new employees and hiding incidents. Research by Rangkuti et al (2018) found that the timing of IKP reporting was not timely due to the failure of socialization and education by the KPRS team to all employees of Bunda Thamrin General Hospital Medan.

One of the special government psychiatric hospitals in Medan City is the Prof. Mental Hospital. Dr. Muhammad Ildrem class A type and referral for other hospitals in North Sumatra Province. Based on a preliminary survey related to IKP, information was obtained that 104 patient safety incidents had occurred from January to June 2021 with details of 1 sentinel incident; 13 KTDs; 12 KNC and 78 Potential Injury Conditions (KPC); and no non-injury events (KTC). Based on the IKP report that the dominant cause was due to patient factors (14 cases); staff factors (10 cases; work environment factors (10 cases) and external factors and communication between officers (1 case).

Judging from the causal factors, it is necessary to improve the work environment such as hospital facilities and infrastructure such as bathroom ceilings, window sills and hospital walls. Then it is necessary to increase the vigilance of the duty officer in the inpatient room towards patients and communication between officers and patients needs to be improved. The presence of patients who are restless, aggressive and have aggressive behavior plays a role in the occurrence of adverse events and a lack of close supervision by room staff plays a role in the escape (IKP RSJ Report Prof. Dr. Ildrem, 2021).

Regarding the reporting of patient safety incidents, information was obtained that until early 2022 reporting was still being done manually by handwriting on the form and in the middle of the year (June) it had been done using the Hospital Management Information System (SIMRS). The main obstacle in its implementation is that there is still no culture of reporting incidents to nurses. The achievement rate for mental patient safety at the Prof. Mental Hospital. Dr.

Muhammad Ildrem is still around 50-80% (Preliminary Research Survey, 2022).

This data proves that the achievement of patient safety goals has not reached the set target of 100%. Seeing that the 100% target has not yet been achieved, the researchers are interested in conducting further research, especially what factors influence the IKP Reporting System.

METHODS

This type of quantitative research with a survey design type of cross sectional design. The research was conducted at Prof. Mental Hospital. Dr. Muhammad Ildrem Medan in August-December 2022. The population is 162 health workers and all of them are the research sample (total population). Primary data was collected by distributing questionnaires containing questions about independent variables: knowledge (20 items), fear (10 items), feedback (10 items), flow/reporting process (10 items), organization/management (10 items) work environment (10 items) and skills (12 items) and the dependent variable: patient safety incident reporting (4 items). Alternative answers for the independent variables consist of: always, often, sometimes and never and for the dependent variable: yes, sometimes and never. Data validity and reliability tests were carried out at the Bina Karsa Mental Hospital in Medan with 30 respondents and the lowest rcount was 0.405 and the highest was 0.931 > rtable, (0.361); the lowest Cronbach alpha value is 0.883 and the highest value is 0.956 > 0.700, it is assumed that the data is valid and reliable. Data were analyzed univariately by describing the frequency distribution of each research variable, bivariately using Pearson product moment correlation and multivariate multiple linear regression test .

RESULTS AND DISCUSSION

Table 1. Distribution of Respondent Characteristics

Characteristics of Respondents	f	%
Age		
< 25 years	2	1,1
25 - 45 years	156	85,7
> 45 years	24	13,2
Gender		
Woman	130	28,6
Man	52	78,6
Education		
Diploma (D3)	78	42,9
Strata (S1) Kep/Ners	97	53,3
Strata (S2)	7	3, 8
Profession		
Specialist	5	2,7
General practitioners	15	8,2
Nurse	162	89,0
Years of service		
1-5 years	78	42,9
6 -10 years	58	31,9
>10 years	46	25,3

The age of the majority of health workers was 25–45 years (85.7%), female (28.6%), graduated from strata 1 education (Kep/Ners) (53.3%), worked as a nurse (89.0%), and years of service (42.9.0%).

Table 2. Frequency Distribution of Research Variables

Variable	f	%
Knowledge		
Good	24	13,2
Pretty good	123	67,6
Not good	35	19,5
Afraid		
Light	26	14,3
Currently	81	44,5
Heavy	75	41,2
Feedback		
Good	20	11,0
Pretty good	135	74,2
Not good	27	14,8
Reporting Flow/Process		
Good	28	15,4
Pretty good	118	64,8
Not good	36	19,8
Organization/Management		
Good	33	18,1
Pretty good	103	66,6
Not good	46	25,3
Work environment		
Support	17	9,3
Enough	105	57,7
Not enough	60	33,0
IKP reporting		
Yes, and no incidents were not reported	30	16,5
Yes, and some incidents go unreported	72	39,6
Yes, and no incidents have been reported	80	44,0

The majority of respondents' knowledge about reporting patient safety incidents (IKP) was quite good (67.6), fear was moderate (44.5%), feedback was quite good (74.2%), flow/reporting process was quite good (64.8%), reporting organization/management was quite good (66.6%), the work environment was quite supportive (57.7%) and IKP reporting in groups, there were incidents and no incidents were reported (44.0%), there were incidents, and some incidents were not reported (39.6%) and there were incidents, and none incidents were not reported (16.5%).

The results of the bivariate analysis obtained the value of the correlation coefficient (r) of the knowledge variable (r 0.180; p 0.015); fear (r 0.395; p 0.000); feedback (r 0.501; p 0.000); reporting flow/process (r 0.492; p 0.000); organization/management (r 0.329; p 0.000); and work environment (r 0.409; p 0.000). The independent variables of knowledge, fear, feedback, flow/reporting process, organization/management and work environment have an opportunity value smaller than $\alpha=0.05$. This means that the variables of knowledge, fear, feedback, flow/reporting process, organization/management and work environment are related to IKP reporting.

The strength of the relationship between variables based on the feedback correlation coefficient, reporting process/flow and work environment is moderate with a value of r (0.400-0.599); the variable of fear and organization/management is low (0.200-0.399) and the variable of knowledge is very low (0.000-0.199). As referred to by Sugiyono (2019) that the coefficient r has a very strong relationship with an interval of 0.800-1.000; Strong with intervals of 0.600-0.799; Medium with intervals of 0.400-0.599; Low with intervals of 0.200-0.399 and Very Low with intervals of 0.000-0.199.

Table 3. Bivariate Analysis

Variable	Pearson correlation (r)	Significance (p)
Knowledge	0.180 (very low)	0 .0 15
Afraid	0.395 (low)	0.000 _
Feedback	0 .501 (medium)	0 ,00 0
Reporting flow/process	0 .492 (medium)	0.000 _
Organization/management	0 .329 (low)	0.000 _
Work environment	0 .409 (medium)	0.000 _

Table 4. Multivariate Analysis

Variable	B grade	Sig.
Constant	-5,717	
Knowledge	0.139	0.000
Afraid	0.015	0.476
Feedback	0.150	0.000
Reporting flow/process	0.042	0.058
Organization/management	0.120	0.000
Work environment	0.030	0.232

The majority of health workers have quite good knowledge (67.6%). Based on the results of multiple linear regression tests, the value of $p = 0.000 < 0.05$ means that there is an effect of knowledge on IKP reporting. In other words, the better the knowledge, the IKP reporting does not necessarily increase.

However, health workers are still found to have less knowledge, this is found in health workers who have just started work. Things that are less known include: the use or determination of incident grading in patients who experience

incidents such as abrasions; identification of incident types and lack of understanding of terms in terms of patient safety incidents.

In line with Octarini's research (2019) explains that there is a relationship between the knowledge of nurses and the supervisory function of the head of the room with the motivation of nurses in reporting patient safety incidents. In line with Dewi's research (2018) it was revealed that the factor that influences IKP reporting is knowledge. Astuti's research (2021) found that the knowledge factor influenced officers in reporting IKP. In contrast to Iskandar's research (2016), individual factors partially, namely knowledge, does not affect the intention to report IKP.

The results of this study support Vincent's (2016) statement that one of the factors that influence patient safety is the knowledge of nurses about patient safety. Also supports the message of the World Health Organization (2020) recommending important aspects of overcoming various obstacles to IKP reporting. A key aspect is ongoing staff education, including an understanding of patient safety culture and the importance of reporting for learning. Fung et al. (2012) and Vrbnjak et al. (2016) also stated that individual

characteristics are factors that are in the first line that have a direct impact on incident reporting. Individual characteristics of health workers include the quality that the individual brings to work in the form of knowledge, attitudes, level of education, motivation, work experience and training.

There is a reasonable influence of the knowledge of health workers on reporting IKP. This is due to the fact that on average health workers already have knowledge and understanding of patient safety and reporting IKP causes if any, and no incidents are reported by health workers. The knowledge factor is an influencing factor for health workers to report patient safety incidents because the knowledge of health workers must continue to be improved, especially knowledge about the reporting system which was still manual in nature to become a computerized system as a means of facilitating reporting.

The majority of health workers have moderate fear (44.5%). The results of the multiple linear regression test showed that the value of $p = 0.476 > 0.05$ means that there is no effect of fear on reporting IKP. This means that the lighter the fear experienced by health workers, the higher the IKP reporting and conversely the more severe the fear, the lower the IKP reporting.

Health workers felt severe fear as seen from the respondents' answers to the statement that they had never felt afraid because if an incident occurred, the hospital management focused on analyzing errors without blaming and the hospital management provided guidance before imposing sanctions if an incident occurred.

In contrast to Astuti's research (2021), the implementation of the reporting system at Hasanuddin University Hospital has been going well. There have been reports of incident types carried out by health workers, using the web application reporting form (SISMADAK), but the fear of reporting is one of the factors affecting officers. Dewi (2018) revealed that one of the inhibiting factors for reporting IKP was fear and hiding incidents.

Research by Naome et al. (2020), the factors hindering IKP reporting are fear of being punished by the administrator and fear of administrative punishment. Research by Hewitt et al. (2017), factors that affect incident reporting include fear of being blamed, fear of being punished and fear of doctors will damage one's reputation as a professional. Research Soydemir et al. (2017) with the finding that factors hindering doctors and nurses from reporting incidents include: fear of being punished and considered incompetent.

This study also does not support the findings of a large-scale survey study which shows that health workers are afraid of being blamed and afraid of being deemed incompetent by colleagues if the officer makes a mistake and the detrimental consequence is termination. Blaming culture still occurs among health workers (Fung et al., 2012).

There is no effect of fear on reporting IKP, which makes sense because the impact of reporting, such as a reprimand or dismissal, does not occur because the average health worker is a State Civil Apparatus. Related to the fact that at the research location it was seen that many health workers had moderate and severe fear, this was found generally in nurses who were young and had just started working compared to nurses who were old and had been working for a long time. The fear of nurses, especially against sanctions from the environment for their inability to implement patient safety.

Health workers felt the feedback was not good (74.2%). The results of the multiple linear regression test value of $p = 0.000 < 0.05$ means that there is a feedback effect on IKP reporting. This means that the better the feedback from

related parties regarding reports of IKP incidents, the better the reporting of IKP by health workers.

Health workers feel that feedback is not good, usually found in health workers who are directly related to incidents. Some health workers stated that feedback was not good, including: sometimes hospital management gave feedback to health workers by informing them of actions to be taken immediately and did not provide feedback through improving the safety of the work system.

In line with the research by Dhamanti et al. (2020), one of the factors hindering IKP reporting is the lack of feedback. Research Joanna et al. (2018), the factor inhibiting low IKP reporting is the level of feedback on reporting patient safety incidents. Research Soydemir et al. (2017), factors inhibiting doctors and nurses from reporting incidents include the absence of feedback after reporting and the failure of management to produce positive feedback.

This study supports the statement of Brunsveld-Reinders et al., (2016), safety feedback should be provided to medical staff with special vulnerabilities in the health care system to increase awareness and should include timely corrective actions to improve patient safety. Feedback that can be given is to provide information to reporters, respond quickly to actions that must be taken, provide information to all front-line personnel, provide information to reporters and the wider community and improve work system security.

The effect of feedback on reporting IKP is reasonable because feedback is a strong basis for health workers to follow up on the management of patients experiencing incidents. Feedback is a response from management regarding incident reporting and is given immediately because it is imperative in solving problems related to patient safety.

Implementation of IKP reporting flow/process is quite good (64.8%). The results of the multiple linear regression test value of $p = 0.058 > 0.05$ means that there is no effect of the flow/reporting process on IKP reporting. In other words, the better or worse the flow/reporting process, has no impact on the reporting of IKP by health workers.

IKP reporting flow/process activities tend to be in a fairly good category. It can be seen from the results of the answers that the flow/reporting process is clear, such as if an incident occurs in a patient it is immediately handled and reported to the direct supervisor which is done a maximum of 2 x 24 hours. Furthermore, the direct supervisor/head of space also conducts a simple investigation before reporting it to the KPPRS Team.

The activity flow/reporting process is not good, including: submitting reports through the official website while health workers do not understand the process. There is also a rule that incidents in patients that are reported to the immediate supervisor are carried out a maximum of 2 x 24 hours. Even though there are times when health workers who are directly involved in incidents are still trying to solve incident cases that have occurred and still have to complete other workloads.

This finding differs from that of Soydemir et al. (2017) revealed factors that hinder doctors and nurses from reporting incidents, including reporting systems that are too complicated and lack functionality because they are not anonymous. Research by Mauti and Githae (2019) found factors influencing the low reporting of medical errors, including: the lack of a medical error reporting system. Habibah and Dhamanti's research (2020) states that organizational factors are associated with low positive feedback on incident reporting and that there has never been an investigation into the root causes of problems.

Astuti (2021) adds that the problem that often occurs is an ineffective reporting system, especially if health workers do not understand the reporting process if there are policy deficiencies, lack of a recording system, lack of standards for reporting and lack of a clear definition of reported errors. The reporting system considered as a burden also affects the level of reporting. Health workers perceive the reporting process as a burden because the documents are detailed and long forms or impractical.

The results of this study do not support the statement of Fung et al. (2012) and Vrbnjak et al. (2016) that policies in the incident reporting system are important that affect incident reporting. The problem that often occurs is ineffective reporting systems, especially if health workers do not understand the reporting process. In addition, the workload of health workers who feel that they do not have enough time to report or even forget to report some medication errors.

There is no connection between the flow/reporting process and IKP reporting because the system implemented is understood by health workers and is easy to implement because it is still manual. However, based on the results of the preliminary survey, it is known that since June 2022 the SIMRS system has begun to be implemented, so that health workers need to adapt to the implementation of this new system.

The organization/management of IKP reporting is quite good (66.6%). The results of the multiple linear regression test value $p = 0.000 < 0.05$ means that there is organizational/management influence on IKP reporting. This means that the better the reporting organization/management, the more IKP reporting increases.

Health workers feel that the reporting organization/management is categorized as not good. According to health workers, hospital management does not provide equipment related to IKP reporting, such as computerized data input devices but it is still manual and hospital management does not provide rewards for health workers if they make incident reports.

In accordance with the research of Matui and Githae (2019) with the results of their research that there is still a lack of a medical error reporting system to support IKP reporting. Research Soydemir et al. (2017) with the finding that factors that hinder doctors and nurses from reporting incidents include management's failure to generate positive feedback. The results of this study support the statement of Fung et al. (2012) and Vrbnjak et al. (2016), the roles and responsibilities of institutions greatly influence the reporting system. A well-designed treatment process depends on organizational management.

There is an influence of organization/management reporting on IKP reporting due to the fact that reporting management is still not optimal, including: the reporting system is still manual. Another reason is that hospital management has not yet provided opportunities for health workers to participate in patient safety training.

The hospital work environment is quite supportive (57.7%). The results of the linear regression test obtained a value of $p = 0.232 > 0.05$, meaning that there is no effect of the work environment on IKP reporting. It means that the work environment has no impact on IKP reporting.

The reporting organization/management seemed quite supportive as can be seen from the answers to the questionnaire that the head of the room did not prohibit the nurse from making a report if an incident occurred and the units in the hospital had worked together to provide the best service for patients to prevent incidents.

In contrast to research by Fung et al. (2012) and Vrbnjak et al. (2016), there are differences in the reporting of medication errors depending on the work environment or work unit. The work environment is the interaction of individuals with their work. work environment can refer to the environment of a department, unit or organization as a whole. The work environment includes factors that influence incident reporting that can determine the quality of health worker safety and service to patients. There are differences in the reporting of medication errors depending on the type of unit the staff works.

In contrast, Habibah and Dhamanti's research (2020) added that the obstacles in reporting patient safety incidents that occurred in hospitals were from organizational factors related to the lack of manager support. The same thing was also expressed by Dhamanti et al. (2020) said that there was a tendency for staff to avoid conflicts among colleagues and the view that reporting incidents experienced by co-workers was not an individual responsibility was also an obstacle in reporting IKP at the hospital.

The work environment as a forum for cooperation with other co-workers where health workers work on a daily basis is definitely implemented well in order to realize patient safety and prevent incidents and IKP reporting actions as soon as possible. The fact is that among health workers there is a tendency to work in teams and always avoid conflict and try to support each other and solve problems when there is an incident with a patient.

CONCLUSIONS

IKP reporting if there is an incident, and no incident is reported to superiors (44.0%). Statistically there is the influence of knowledge of doctors and nurses, feedback, organization/management of IKP reporting. But there is no effect of fear of doctors and nurses, flow/reporting process and work environment on IKP reporting. It is recommended that patient safety incident reports should be available at each room unit to make it easier to see the number of incidents that occurred and the stage of completion and provide feedback as quickly and precisely as possible.

ACKNOWLEDGEMENTS

We are very grateful to experts for their appropriate and constructive suggestions to improve this template.

Conflict of Interest

The authors declare no conflicts of interest in this study.

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