

Investigating Between Patient Safety Culture, Organizational Climate, and A Positive Workplace on Reporting of Patient Safety Incidents in Hospital

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INDEXING

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ABSTRACT

Many patient safety incidents (PSIs) begin the hospital's safety system establishment, which is oriented toward patient safety. The importance of PSI reporting is of particular concern to WHO. Therefore, comprehensive guidance exists on designing, implementing, and applying good PSI reporting. This research is a non-experimental design using SEM analysis techniques, and it is processed using the SMARTPLSv3 application. This study aims to determine the effect of patient safety culture (X1), organizational climate (X2), and a positive environment (X3) on motivation to report PSI (Y1). The research sample was the X Semarang Hospital staff, with 200 respondents. The results showed that the Patient Safety Rate at X Semarang Hospital was in a suitable category of 54%, even though the number of PSI reported was in the low category. The SEM analysis result indicated that the construct of the X1 and X2 variables after modification was valid and reliable. Moreover, there was a positive and significant effect of X1 and X2 on Y1 with an effect size of 0.042 (small) and 0.490 (large). However, X2 did not have a significant influence on Y1. The hierarchy culture implemented in X Hospital didn't affect motivation for the reporting of patient safety incidents (PSI). It even tends to have an indirect negative influence through a supportive environment variable.

Kata kunci:

Budaya Keselamatan
Pasien;
Budaya Organisasi;
Insiden
Keselamatan Pasien;
Motivasi Melaporkan
IKP;
PLS-SEM

Banyaknya Insiden Keselamatan Pasien (IKP) menjadi awal dibentuknya suatu sistem keselamatan di Rumah Sakit yang berorientasi pada keselamatan pasien. Pentingnya pelaporan IKP menjadi perhatian khusus bagi WHO, sehingga diterbitkan panduan yang komprehensif tentang cara merancang, menerapkan, dan menggunakan pelaporan IKP yang baik. Penelitian ini merupakan Non Eksperimental Design menggunakan teknik analisis SEM dan diolah menggunakan aplikasi SMARTPLSv3 yang bertujuan untuk mengetahui pengaruh budaya keselamatan pasien (X1), Budaya Organisasi (X2) dan lingkungan yang mendukung (X3) terhadap motivasi pelaporan IKP (Y1). Sampel penelitian adalah staf di RS X Kota Semarang sejumlah 200 responden. Hasil menunjukkan bahwa peringkat Keselamatan Pasien di Rumah Sakit X Kota Semarang terkategori baik yaitu sebesar 54% walau jumlah IKP yang dilaporkan dikategorikan rendah. Hasil analisis SEM memperlihatkan konstruk yang valid dan reliabel setelah dimodifikasi, serta terdapat pengaruh yang positif dan signifikan X1 dan X3 terhadap Y1 dengan besar efek senilai 0.042 (kecil) dan 0.490 (kuat), akan tetapi X2 tidak memberikan pengaruh yang signifikan terhadap Y1, hal tersebut menunjukkan bahwa budaya hierarki yang diterapkan pada RS X tidak mempengaruhi motivasi pelaporan IKP bahkan cenderung memberikan pengaruh negatif secara tidak langsung jika melalui variabel lingkungan yang mendukung.

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INTRODUCTION

A hospital, as a place of modern health care, is a complex organization, so it is hardly surprising that patient safety incidents occur. Patient safety culture is the main foundation for preventing and reducing the occurrence of Patient Safety Incidents (PSI), which include Unexpected Incidents, Near Miss Incidents, non-injury incidents, and potential injury incidents that result in the occurrence of injury or death in patients (Karmila et al., 2023).



Therefore, it is important to implement a correct patient safety culture in the form of objective and accurate patient safety incident reports.

In Patient Safety Incident (PSI) reporting in Indonesia, 7.465 cases occurred in 2019, consisting of 171 deaths, 80 serious injuries, 372 moderate injuries, 1.183 minor injuries, and 5.659 no injuries (Daud, 2020). A large number of Patient Safety Incident (PSI) becomes the beginning of the safety system establishment in hospitals, which is oriented towards patient safety. Patient safety is a top priority in health services so that there is no danger threatening the patient during services (Wianti et al., 2021). Regulation of the Minister of Health No. 11 of 2017 has regulated patient safety as crucial in operating patient safety in hospitals throughout Indonesia. Therefore, this regulation can provide guidance and motivation for hospital management to run a patient safety system as a whole (Ministry of Health, 2017).

Patient Safety Incident reporting is one of the ways and requirements to build a culture of patient safety, which aims to reduce Patient Safety Incidents. It also has an ultimate goal, which is to improve service quality and patient safety. By reporting Patient Safety incidents, the clinical management can find out its causes to the root of the problem and be able to improve patient care quality to prevent similar incidents from happening in the future (KKPRS, 2015). In Indonesia, the implementation of patient safety incident reporting is less than optimal because people are afraid of being punished, blamed, judged as incompetent, damaging their reputation, and receiving legal consequences and intimidation if they report an incident. Then, a lack of knowledge also makes them think that reporting is not considered an obligation. Thus, it makes them decide not to make a report if an incident/accident occurs (Rombeallo et al., 2022).

According to the Agency of Healthcare Research and Quality (AHRQ) in Hospital Survey on Patient Safety Culture Verse 2.0 in 2019, to build a patient safety culture in the hospital, several aspects need to be considered, one of them is patient safety events reporting (Sorra et al., 2018). Several studies have concluded that the culture of patient safety simultaneously has a significant effect on attitudes and motivations for reporting patient safety incidents (Anggraeni et al., 2016 & Wulandari et al., 2019) as well as the rate of reporting patient safety incidents (Yoo & Kim, 2017).

Organizational climate is an indispensable part of hospital institutions (Widyanti & Agrianti, 2016) because, in inpatient treatment, the staff needs to build good teamwork and uphold organizational climate (Rahma & Mas'ud, 2016). On the one hand, research conducted by Chiu concluded that the organizational climate supporting patient safety in hospitals is a Hierarchy culture (Levine et al., 2020). Still, on the other hand, research by Afrisya conducted in Jakarta showed that the Clan culture is the dominant organizational climate type and became a guide for organizations in developing patient safety (Irviranty, 2015). An organization that respects patient safety will instill these values in staff and employees to build a culture to prevent mistakes and a motivation to report the errors promptly when they occur (Rogers, 2016).

The importance of reporting safety incidents is of particular concern to the World Health Organization (WHO). Thus, in 2020, WHO published Patient Safety Incident Reporting and Learning Systems: Technical Report and Guidance as a comprehensive guide for health ministries, hospitals, and health facilities on how to design, implement, and use

patient safety reporting well. This guide describes the favorable environment for reporting patient safety incidents. The guide explains that in implementing a patient safety incident reporting system in large and small healthcare institutions, the first thing is to create a positive environment where staff are motivated and feel valued for participating in patient safety incident reporting (WHO, 2020).

Aspects of the environment that support patient safety incident reporting are expected to build the motivation of all hospital staff and employees to report patient safety incidents that they encounter. Paramita et al. (2020), in their research, concluded that the factors of responsibility, recognition, policy, and working conditions are related to nurses' motivation in reporting patient safety incidents. The expected working condition, in this case, is a working environment in the hospital that supports the reason for reporting a Patient Safety Incident.

X Hospital in Semarang City realizes the importance of being oriented toward patient safety, providing the best and most comprehensive service to the community, and achieving an outstanding level in the accreditation survey by KARS. In its implementation, it encounters obstacles, namely the under-reporting of Patient Safety Incidents (PSI). Based on data from the staff of the PMKP Committee of X Hospital in Semarang City, reported patient safety incidents totaling 38 cases (2019) and 2 points (2020). In 2019, reported patient safety incidents comprised 40% near-fall incidents, 25% medication errors, 15% misidentified, and 20% problems related to room infrastructure.

Since patient safety incident reporting is one of the ways to improve patient safety at X Hospital in Semarang City, the researchers are interested in analyzing the effect of patient safety culture and positive environment on the motivation to report patient safety incidents at X Hospital in Semarang City.

RESEARCH METHOD

This study used a Non-Experimental Descriptive correlational research design with a Quantitative approach using Structural Equation Modeling (SEM) analysis techniques to determine the effect of Patient Safety Culture, Organizational climate, and Positive Environment on Motivation to report Patient Safety Incidents. The population in this study was all general administration staff and clinical units at X Hospital Semarang City, with a total of 330 people. This study used the probability sampling technique with Proportionate Stratified Random Sampling. The sample size used in this study was determined by the Slovin Formula and Hospital Survey on Patient Safety Culture Version (HSOPS) 2.0 AHRQ guide, which recommends that the minimum sample limit used in studies using the HSOPS version 2.0 instrument was 200 respondents.

The data collection in this study was a questionnaire with score criteria based on the Likert scale, which respondents directly filled out in the form of a hard file.

Patient Safety Culture variables were measured using an instrument in the form of the Hospital Survey on Patient Safety Culture Edition 2.0 (HSOPS 2.0) questionnaire from the Agency for Healthcare Research and Quality, published in 2019). The positive environment variable was measured using a questionnaire based on WHO's Patient Safety Incident Reporting And Learning Systems: Technical Report And Guidance. Then, the motivation to Report Patient Safety Incidents variable was measured using a questionnaire based on

Herzberg's Motivation theory, which used the Hygiene factor as an indicator. Data from questionnaires and observations were in Ms. Excel to be tabulated, coded, and grouped based on variables and indicators. Data were exported into the SmartPLS 3 program to be analyzed with the Partial Least Square - Structural Equation Modeling (PLS-SEM) technique to maximize the R-Square value and minimize residual or prediction errors (Sholihin & Ratmono, 2020:7). The specification of the constructed model in this study presented in Table 1.

Table 1. Model Specification

Latent Variable	Indicator (Observed Variables)
Exogenous Latent Variable (Independent)	
Patient Safety Culture (X1)	Communication about errors (X1.1) Communication Openness (X1.2) Handoffs and information exchange (X1.3) Hospital management support for patient safety (X1.4) Organizational learning – Continuous Improvement (X1.5) Patient Safety Incident Reporting (X1.6) Response to errors (X1.7) Staffing and Work Pace (X1.8) Supervision, manager or clinical leader support for patient safety (X1.9) Teamwork (X1.10)
Organizational Culture (X2)	Dominant Characteristics (X2.1) Organizational Leadership (X2.2) Staff Management (X2.3) Relationships within the Organization (X2.4) Strategic Emphasis (X2.5) Success Criteria (X2.6)
Endogenous Latent Variable (Dependent)	
Supportive Environments in PSI reporting (X3)	Leaders prioritize patient safety (X3.1) No Blaming and retribution culture in the hospital (X3.2) Easy PSI Reporting instrument (X3.3) Sufficient Time for Staff to make PSI report (X3.4) Regular training on PSI and its reporting (X3.5) Feedback from leaders on reported PSI (X3.6)
Reporting Motivation (Y1)	Semarang City X Hospital Policy on PSI reporting (Y1.1) Working unit conditions on Patient Safety Incidents and their reporting (Y1.2) Incentives or rewards for those who report PSI (Y1.3) Supervision from management on PSI (Y1.4)

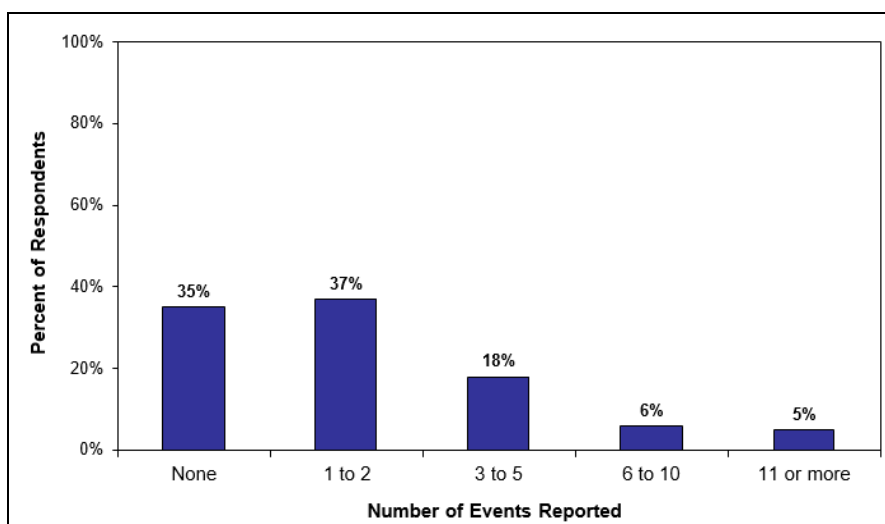
Source: primer data, 2023

Model construct evaluation consists of the analysis of the outer model and inner model. Outer model evaluation is carried out on each construct or measurement model separately by evaluating the convergent validity, discriminant validity, and internal consistency reliability (Composite reliability and Cronbach alpha) of the measurement model. Meanwhile, in assessing the inner model, three things need to be considered: the value and sign (direction) of the relationship on the value of the path coefficient, the significance of the estimated parameter, and the coefficient of determination (R^2) and effect size. If there are invalid or reliable constructs in the outer model test, the model can be corrected (re-specified) by eliminating invalid constructs.

RESULTS AND DISCUSSION

Semarang City X Hospital is a public hospital owned by the Indonesian Army with a capacity of 151 beds. 200 staff working at Hospital X Semarang City were respondents. The majority were women, ranging in age from 28 to 43 years. Respondents also mostly have the last education D3 / S1. 46% of respondents worked there for more than ten years, and the majority of respondents were nurses. The results showed that the descriptive patient safety culture variable was analyzed using the SOPS 2.0 Hospital Survey presented in 3 points.

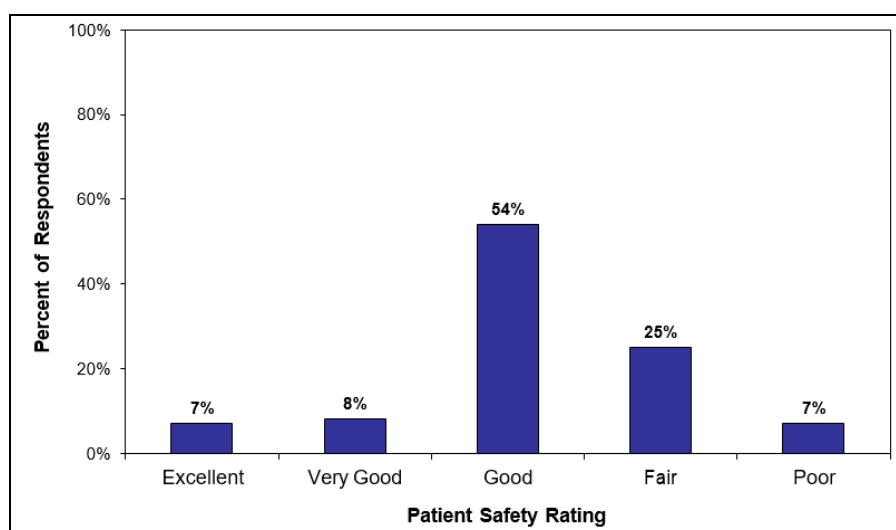
1. Number of patient safety incidents reported by respondents



Picture 1. Number of Reported Patient Safety Incidents in the Last 12 Months

Source: Data Primer 2023

2. Patient safety rate in each respondent's work unit

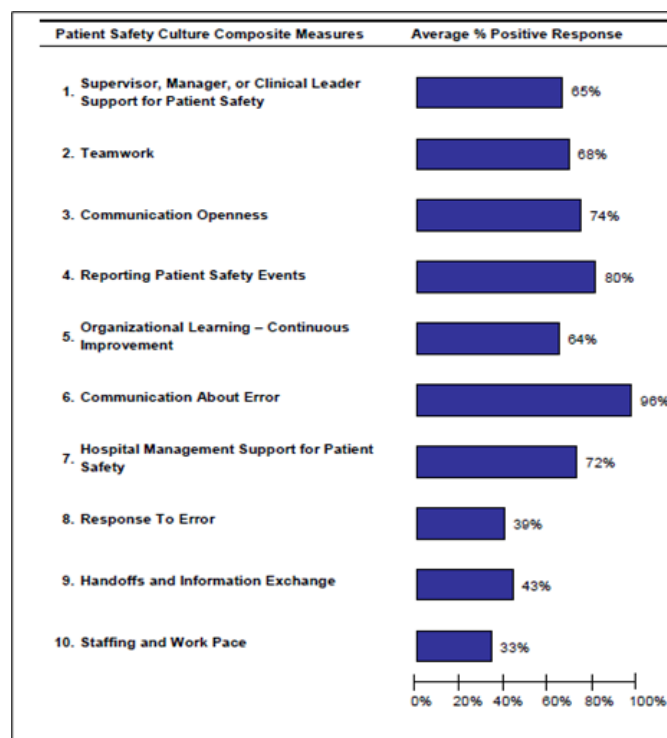


Picture 2. Patient Safety Rating at X Hospital

Source: Data Primer 2023

Picture 1 and Picture 2 show that the Patient Safety rate at the X Hospital is in the good category, which is 54%. However, the number of reported Patient Safety Incidents (PSI) is low: staff who report 1-2 Patient Safety Incidents in a year by 37% and staff who do not report Patient Safety Incidents by 35%.

3. Assessment of area of the same patient safety culture



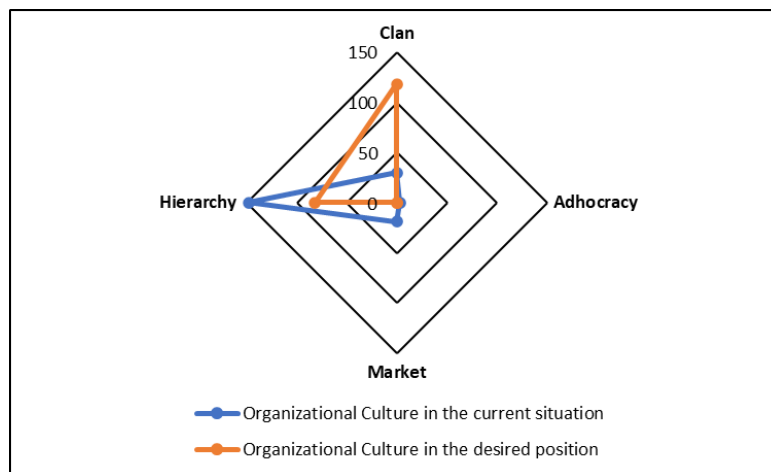
Picture 3. Percentage of 10 Patient Safety Culture Composites at X Hospital

Source: Data Primer 2023

Picture 3 shows the results of the composite measurement of Patient Safety Culture at Hospital X Semarang City, showing that the lowest areas of Patient Safety Culture are in the Staffing and Work Pace and the Response To Error). In the Staffing and Work Pace area, ideally, there are enough staff to handle the workload and staff work according to working hours and do not feel rushed, but based on the results of composite measurements, which show a percentage of 33% concluded that there is a shortage of staff to carry out the workload and staff work in a hurry.

In the Response To Error area, ideally, staff should get fair treatment when they make mistakes so that they can focus on learning. Still, the composite measurement showed a 39% percentage that the team felt they didn't get fair treatment when they made mistakes, and no evaluation focused on learning from mistakes.

Then, a comparative analysis of the frequency of Organizational Culture at Hospital X Semarang City in its current and desired conditions is presented in Picture 4 below.



Picture Error! No text of specified style in document.. Comparison Graph of the frequency of culture type in the Current Situation and the Desired Situation

Source: Data Primer 2023

According to Picture 4, the most dominant organizational culture in the current situation is Hierarchical culture. Meanwhile, the Organizational Culture in the desired position is dominated by Clan culture. This research finding is similar to Mesfin's study conducted in Jimma Barat Daya Ethiopia General Hospital in the 2020 BMC Health Services Research, which revealed that a typical Hierarchy culture, namely formal rule, procedure, and strict supervisory management, dominated the organizational culture currently experienced at Jimma Barat Daya Ethiopia General Hospital. In the same way, research conducted at Quang Nam Vietnam Center General Hospital indicated that their organizational culture in the current situation was a Hierarchy, which had an internal focus that appreciated the importance of internal stability rather than developing competitive positioning. This organizational culture is often seen in government-funded organizations (Nguyen Van et al., 2018). Furthermore, the results of the supporting environment variable descriptive (X3) are presented in Table 2.

Table 2. Descriptive Statistic Supportive Environment

Indicator	Mean	Std. Dev
Leaders prioritize patient safety (X3.1)	4.11	0.54
No Blaming and retribution culture in the hospital (X3.2)	3.27	1.16
Easy PSI Reporting instrument (X3.3)	3.87	0.71
Sufficient Time for Staff to make PSI report (X3.4)	3.97	0.56
Regular training on PSI and its reporting (X3.5)	3.89	0.72
Feedback from leaders on reported PSI (X3.6)	3.87	0.61
Total average	3.83	0.45

Source: Data Primer 2023

Table 1 shows the highest average scores on the leader prioritizing patient safety indicator (X3.1) with a score of 4.11 and on the sufficient time indicator for staff to make PSI reporting (X3.4) with a score of 3.97. Respondents (hospital staff) responded quite well to leaders who gave instructions to prioritize patient safety. Then, hospital management gave the

team sufficient time to make patient safety incident reports so that staff could feel that the work environment at Hospital X was very supportive in conducting and making patient safety incident reports. The results of the motivation for reporting patient safety incident variables are presented in Table 3.

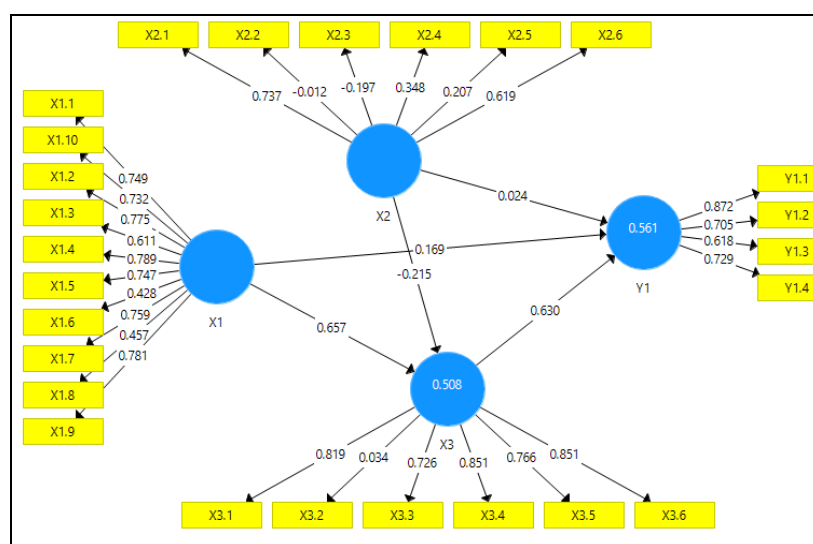
Table 3. Descriptive Statistic Motivation for Reporting Patient Safety Incidents

Indicator	Mean	Std. Dev
Semarang City X Hospital Policy on PSI reporting (Y1.1)	4.01	0.51
Working unit conditions on Patient Safety Incidents and their reporting (Y1.2)	3.96	0.44
Incentives or rewards for those who report PSI (Y1.3)	4.14	0.58
Supervision from management on PSI (Y1.4)	3.72	0.62
Total of average	3.96	0.56

Source: Data Primer 2023

Based on Table 3, the highest average score is found in the X Hospital Policy indicator on PSI reporting (Y1.1) with a score of 4.01 and the incentive or reward indicator for those who report PSI (Y1.3) with a score of 4.14. A relatively high average score on Y1.1 and Y1.3 indicators show that respondents (staff at hospital X) will be more motivated in conducting and reporting patient safety incidents if there is a good policy from the hospital regarding patient safety incidents reporting and there is more appreciation for hospital staff who report patient safety incidents.

Analysis of the effect of Patient Safety Culture (X1), Organizational Culture (X2), and Positive Environment (X3) on Motivation to Report Patient Safety Incidents (Y1) using PLS-SEM shows the following results in Figure 5.



Pictures 5. Full Model Path

Source: Data Primer 2023

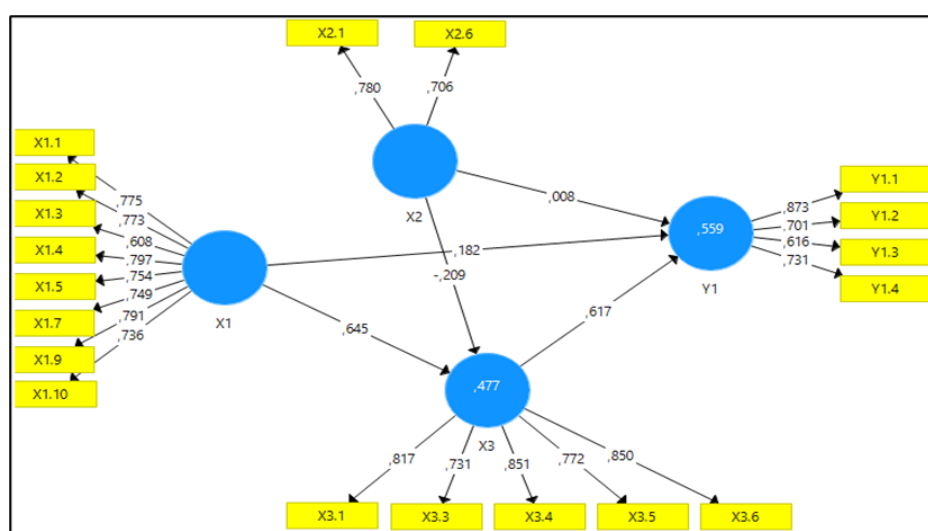
Picture 5 shows the full model path with several invalid indicators. The results of the Convergent Validity analysis show that two indicators in variable X1 are invalid, namely X1.6 and X1.8. The patient safety Incident Reporting Indicator (X1.6) is invalid because

respondents felt they had reported the PSI verbally to the Head of the room or the staff who worked on the next shift. Still, the team didn't follow up on it as a written PSI report, which the Quality Committee of RS X Semarang City documented. This gap is supported by the high percentage of positive responses from the Patient Safety Incident Reporting composite of 80% (picture 3), but the value of the *Outer Loading* X1.6 indicator is invalid ($<0,5$). Staffing and Work Pace Indicator (X1.8) is invalid because respondents assume that there are only a few staff who carry out the routine tasks or it is not comparable with the workload when the sufficient number of competent and professional health workers affects the implementation of health services, maintain service quality and patient safety in hospitals (Asmirajanti et al., 2021).

The availability of adequate health workers in terms of profession and quantity is a requirement for the implementation of health services in hospitals. Competent health workers must provide hospital services following their responsibilities and clinical authority. It is necessary to increase the number of health workers in line with the number of COVID-19 patients to prevent fatigue and stress, not to mention resources that must be managed well to maintain the quality of service and patient safety.

Then, four indicators in the X2 variable are invalid; they are X2.2, X2.3, X2.4, and X2.5. Then, one indicator in the X3 variable is invalid; it is X3.2. In addition, the AVE value for X1 and X2 variables is also less than 0.5. Moreover, the output discriminant validity value shows that the cross-loading value of each indicator on each variable is higher than the cross-loading value of the indicators on the other variables, except for X2.2, X2.3, and X3.2 indicators, which indicates that those indicators do not meet the *Discriminant Validity* criteria. This finding concludes that the construct still does not meet the construct validity requirement, so the model needs to be improved.

Modification of the model is done by removing invalid indicators in the outer model results, which have been analyzed in Table 3, so that the removed indicators in this model improvement are X1.6, X1.8, X2.2, X2.3, X2.4, X2.5, and X3.2. The results of the SEM analysis after the model improvement are presented in Picture 6 below.



Picture 6. Full Model Path Modification

Source: Data Primer 2023

According to the result of the complete model modification output in Picture 6, the convergent validity analysis of the modified model shows that all indicators have *outer loading* value $> 0,5$ and AVE value of $> 0,5$, meaning that the construct has met the requirement to fulfill convergent validity. Meanwhile, the output results of the discriminant validity value of the modified model indicate that the cross-loading value of each indicator on each variable is higher than the cross-loading value of the indicators on the other variables, meaning that the indicator has met the Discriminant Validity criteria.

Communication about errors is essential in a patient safety culture since it is used to interact and exchange information among team members appropriately to minimize mistakes that could harm patients, for example, the duty handover process at each change (Yanriatuti et al., 2020). The handover of duty and information exchange in each shift change is essential in patient care because it shows a health worker's competency in maintaining effective care and protecting patient safety (Cahyaningtyas et al., 2020). Open communication positively impacts patient safety in hospitals because the staff can willingly express their opinions when they find something that might threaten patient safety and do not hesitate to ask or convey it to higher authorities (Top & Tekingündüz, 2015).

Then, the indicator of hospital management support for patient safety can be observed from hospital management policies which prioritize patient safety in the form of providing facilities and human resources for the Hospital Quality Committee, motivating staff about the importance of patient safety, and holding training activities related to patient safety (Wulandari et al., 2023). The next forming indicator is organizational learning culture, which is an effort to increase the insight and skills of hospital staff in running the organization so that they can face problems related to patient safety with a fast and appropriate response. Hospital staff are expected to learn from the experience and enhance their performance in hospital health services (Yanriatuti et al., 2020). In addition, the teamwork indicator is also supposed to be one of the domains of patient safety culture in which staff have to work together to build a cohesive team when providing health services and minimize the conflict among the staff that can lead to the lack of the quality of health services in hospitals (Yanriatuti et al., 2020). However, errors must be responded to appropriately if a patient safety incident still occurs. Response to mistakes is considered good if built in a cultural environment that does not blame the situation. Still, it is oriented toward the root cause of an error and to be evaluated for it so that similar mistakes do not occur (Anggraeni et al., 2016).

Then, the construct reliability test aims to show how well a research model construct produces consistent results. The construct reliability test uses the value of composite reliability and Cronbach alpha. A variable is considered reliable if it has a combined reliability value above $\geq 0,6$ and a variable Cronbach alpha value of $\geq 0,7$. However, an unreliable construct remains after the model is modified, namely the X2 variable. It means that the X2 construct cannot measure a value consistently in the same population. X2 is still applied in this research to find out the value of the correlation with other latent variables.

The inner model analysis consists of hypothesis testing (significance) of the R square value and the F square value obtained using the bootstrapping method on the modified model. The finding is presented in Table 5 and Table 6 below.

Table 5. Hypothesis Testing

Path	Coef	St. Dev	T - Statistics	P - Values	Decision
Patient Safety Culture -> Positive Environment	0.645	0.048	13.362	0.000	Significant
Organizational culture -> Positive Environment	-0.209	0.068	3.074	0.002	Significant
Patient Safety Culture -> Motivation to Report Patient Safety Incidents	0.182	0.085	2.15	0.032	Significant
Organizational Culture -> Motivation to Report Patient Safety Incidents	0.008	0.063	0.12	0.905	Insignificant
Positive environment -> Motivation to Report Patient Safety Incidents	0.617	0.073	8.433	0.000	Significant

*Source: Data Primer 2023***Table 6. R-square dan F-square**

Path	F square	R square	Effect Size
Patient Safety Culture -> Positive Environment	0.791	0.477	Large
Organizational culture -> Positive Environment	0.083		Small
Patient Safety Culture -> Motivation to Report Patient Safety Incidents	0.042		Small
Organizational Culture -> Motivation to Report Patient Safety Incidents	0.000	0.559	No effect size
Positive environment -> Motivation to Report Patient Safety Incidents	0.452		Large

Source: Data Primer 2023

In Table 5 and Table 6, we can see a positive and significant influence of the Patient Safety Culture variable on the Supporting Environment to Report PSI with an effect size of 0.791 (large). This finding is supported by research conducted in Karya Bhakti Pratiwi Bogor Hospital, which concluded that Patient Safety Culture is related to 3 dimensions they are feedback on incident reports, Non Punitive Cultures, and Learning Cultures (Yasmi & Hasbullah, 2018), all three of which are part of the Supportive Environment in Patient Safety Incident Reporting. Meanwhile, there is a negative and significant influence of the Organizational Culture variable on the environment that supports PSI Reporting with an effect size of 0,083 (small). The current condition of organizational culture, which is hierarchical culture, influences the reduction of a supportive environment in PSI reporting at X Hospital. This finding is supported by (Lee et al., 2021) research on several health facilities in Canada, which concluded that a robust Hierarchy Culture brings out a high blaming culture in the Patient Safety Program. High Blaming culture indicated that the environment in PSI reporting is less than ideal. In the same way, Monga et al. (2015) conducted a study on the hierarchy culture in India's pharmaceutical industry. Hierarchy Culture causes poor motivation in workers due to strict rules and a lack of appreciation.

There is a positive and significant influence on Patient Safety Culture and Supportive Environment in PSI Reporting on Motivation to Report Patient Safety Incident variable with the effect size of 0,042 (small) and 0,452 (large). The results are supported by a *Systematic Review* from *Health Quality Ontario*, which concluded that successful Patient Safety Incident Reporting is formed from a non-punitive environment, management that provides reporting feedback, and training that builds technical understanding of Patient Safety Incident Reporting (Health Quality Ontario, 2017). Meanwhile, there is no significant influence of Organizational Culture on the Motivation to Report Patient Safety Incident variable, even

though the effect size is worth 0,000 (very small/ none). This result is supported by a study by (Megantara et al., 2019), which assumed that Organizational culture does not affect worker's motivation or performance due to organizational culture is correlated to situations, paradigms, feelings, and behavior that can influence staff's motivation and performance (Ainur & Satria, 2018). The mediation Effect (indirect effect) X1 and X2 on Y through X3 is shown in Table 7.

Table 7. Indirrect Effect Value

Path	Indirect Effects After Modification
Patient Safety Culture -> Positive Environment -> Motivation to Report Patient Safety Incidents	0.398
Organizational culture -> Positive Environment -> Motivation to Report Patient Safety Incidents	-0.129

Source: Data Primer 2023

The result of the mediation analysis of Patient Safety Culture (X1) on Motivation to Report Patient Safety Incidents variable (Y1) through the Supportive Environment in Patient Safety Incident Reporting variable (X3) provides a positive indirect influence. This result means that the Supportive Environment in PSI Reporting (X3) can indirectly improve the correlation between Patient Safety Culture (X1) and Motivation for Reporting Patient Safety Incidents Motivasi (Y1) at X Hospital in Semarang. This finding is supported by a study by Abuosi et al. on 13 Hospitals in Ghana, which revealed that the low number of Patient Safety Incident Reports could predict a poor Patient Safety Culture. Meanwhile, increasing Patient Safety Incident Reports requires hospital managers to implement a Non-Punitive or No Blaming Culture and reward staff who report unwanted incidents (Abuosi et al., 2022). The existence of managerial and clinical commitment to implement the No Blaming Culture culture and provide rewards is a manifestation of a Supportive Environment in PSI reporting (World Health Organization, 2020).

The result of the mediation analysis of the Organizational Culture variable (X2) on the Patient Safety Incident Report (Y1) through the Supportive Environment to Report the Patient Safety Incident variable (X3) has a negative indirect influence. It shows that the Supportive Environment to Report Patient Safety Incident variable (X3) indirectly reduces the correlation of the Organizational Culture variable (X2) on Motivation to Report Patient Safety Incident variable (Y1) at X Hospital in Semarang.

The results of the analysis are described as follows: Organizational Culture analysis using the Competing Values Framework method shows that the Organizational Culture currently at Hospital X is a Hierarchy Culture. Meanwhile, Clan Culture is the expected organizational culture in the future (Picture 4). Hierarchy Culture is characterized by being oriented on formal and neatly structured work rules, with a strict supervisory function, and the leader acts as a coordinator (Putra, 2017). Connected with mediation analysis results of Organizational Culture variable (X2) on Motivation to Report Patient Safety Incident variable (Y1) through Supportive Environment to Report Patient Safety Incident variable (X3) which has a negative indirect influence shows that Supportive Environment to Report Patient Safety Incident variable (X3) indirectly reduces the correlation of Organizational Culture (X2) on Motivation to Report Patient Safety Incident variable (Y1) because X

Hospital's management or leader in Semarang does not carry out the role as coordinator of Patient Safety Incident Report so that it does not run optimally. It is verified from the results of interviews with the Quality Committee of the Patient Safety Sub-Committee of X Hospital, who stated that there is an SOP regarding Patient Safety and Patient Safety Incident Report (PSI), but it is not regularly disseminated. In practice, the SOP was given once in 2019 before the pandemic. That situation proves the low frequency of dissemination regarding the Patient Safety Incident Report (PSI). Then, even though the Patient Safety Incident Report (PSI) SOP has been created, no leader regularly oversees the number of Patient Safety Incident (PSI) Reports. The Patient Safety Sub-Committee tends to be passive by waiting for the Patient Safety Incident (PSI) report.

In conclusion, the leadership in the organizational culture of Hierarchy at X Hospital in Semarang does not run well, so it does not support the Motivation to Report Patient Safety Incidents, not to mention the Blaming culture and Retribution indicator in a highly Supportive Environment to Report Patient Safety Incident variable, make Motivation to Report Patient Safety Incident low. It can also be concluded that the leadership or management at X Hospital in Semarang does not yet have a solid commitment to prioritizing the Patient Safety Incident Report. Meanwhile, the respondents assume that a leader who prioritizes patient safety (X3.1) is the most encouraging indicator in the Patient Safety Incidents Report. Rivai et al. (2016) showed a correlation between superior leadership and the implementation of patient safety in Regional General Hospital.

CONCLUSION

Based on the results and discussion described, there was a positive and significant effect on the Patient Safety Culture variable and Supportive Environment in PSI Reporting on Motivation for Reporting PSI with effect sizes of 0.042 and 0.452. A positive and significant influence is also shown on the Patient Safety Culture variable on Supportive Environment in PSI Reporting with an effect size of 0.791. However, there is no significant influence on the Organizational Culture variable on PSI Reporting Motivation. Furthermore, the Patient Safety Culture variable on motivation for reporting PSI through a supportive environment for reporting PSI has a positive indirect influence with an indirect effect value of 0.398.

Suggestions for Hospital X regarding this research are as follows: Hospital X's quality committee could frequently provide familiarization and evaluation regarding patient safety culture and patient safety incident reporting to all staff. Moreover, Hospital X management could give rewards for units that report patient safety incidents, re-evaluate the gaps that occur between the hierarchy culture type and the conditions that happen in the real world, optimize leadership changes that provide targeted instructions to prioritize patient safety, as well as giving sufficient time for staff to report patient safety incidents.

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Hospital in Semarang. This study is dedicated to the management of X Hospital in Semarang to implement a supportive environment in PSI Reporting as a form of commitment that the management of X Hospital in Semarang prioritizes patient safety.

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