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THE EFFECT OF PATIENT SAFETY CULTURE AND INCIDENT REPORTING ON THE OCCURRENCE OF PATIENT FALLS

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Abstract

Patient falls are one of the most common adverse events in healthcare settings and have significant impacts on patient safety and quality of care. This study aims to analyze the effect of patient safety culture and incident reporting on the occurrence of patient falls at Hospital X. The research used a quantitative approach with a cross-sectional design. The population consisted of healthcare workers involved in patient care, with a sample selected using purposive sampling. Data were collected through structured questionnaires and analyzed using multiple linear regression. The results showed that patient safety culture has a significant negative effect on patient falls, indicating that a stronger safety culture contributes to reducing fall incidents. Incident reporting also has a significant negative effect, suggesting that effective reporting systems help in identifying and preventing fall occurrences. Simultaneously, patient safety culture and incident reporting have a significant effect on patient falls, as indicated by the F-test results. The coefficient of determination (R^2) shows that both variables explain 32.1% of the variation in patient falls.

Keywords: Patient Safety Culture, Incident Reporting, Patient Falls

INTRODUCTION

Patient falls remain one of the most common and preventable adverse events in healthcare settings, contributing significantly to patient morbidity, prolonged hospitalization, increased healthcare costs, and even mortality. Falls can occur in various clinical environments, including hospitals, long-term care facilities, and outpatient settings, often involving vulnerable populations such as the elderly, patients with mobility limitations, and those with cognitive impairments. Despite ongoing efforts to improve patient safety, the incidence of patient falls continues to present a serious challenge for healthcare systems worldwide (Suparjo et al., 2025). A critical factor influencing the occurrence of patient falls is the implementation of a strong patient safety culture. Patient safety culture refers to the shared values, beliefs, norms, and practices within a healthcare organization that prioritize safety in every aspect of care delivery (Utami et al., 2023). A positive safety culture encourages open communication, teamwork, leadership commitment, and adherence to safety protocols. When healthcare professionals are supported by a robust safety culture, they are more likely to identify potential risks, follow fall prevention procedures, and engage in proactive measures to protect patients from harm (Kadarisman & Wirawan, 2025).

In addition to safety culture, incident reporting systems play a vital role in reducing the occurrence of patient falls. Incident reporting involves documenting and analyzing adverse events, near misses, and unsafe conditions to identify root causes and implement corrective actions (Sihbudi, 2025). Effective reporting systems enable healthcare organizations to learn from errors, improve clinical practices, and develop targeted interventions for fall prevention. However, underreporting remains a significant issue, often caused by fear of blame, lack of awareness, or inadequate reporting mechanisms, which ultimately limits the effectiveness of safety improvement efforts (Delpita & Kosasih, 2024). The relationship between patient safety culture and incident reporting is closely interconnected. A supportive safety culture fosters transparency and encourages healthcare workers to report incidents without fear of punishment (Mustoha et al., 2025). Conversely, active and consistent incident reporting contributes to strengthening the safety culture by promoting organizational learning and continuous quality improvement. Together, these factors are expected to have a significant impact on reducing the incidence of patient falls (Wa'os et al., 2024). Given the persistent challenges associated with patient falls and the importance of preventive strategies, it is essential to examine how patient safety culture and incident reporting influence the occurrence of such events. Understanding this relationship can provide valuable insights for healthcare institutions in developing more effective policies,

enhancing staff awareness, and ultimately improving patient safety outcomes. Therefore, this study aims to analyze the effect of patient safety culture and incident reporting on the occurrence of patient falls.

LITERATURE REVIEW

Patient Safety Culture

Patient safety culture is defined as the shared values, beliefs, and norms within a healthcare organization that influence attitudes and behaviors related to patient safety. It reflects how safety is prioritized, communicated, and implemented in daily clinical practice. Key dimensions of patient safety culture include leadership commitment, teamwork, communication openness, organizational learning, and a non-punitive response to errors (Wa'os et al., 2024). A strong patient safety culture plays a crucial role in preventing adverse events, including patient falls. Healthcare professionals who work in environments with a positive safety culture are more likely to follow safety protocols, identify potential risks early, and take preventive actions. Studies indicate that units with high levels of teamwork and effective communication tend to have lower rates of patient falls because staff are more coordinated in monitoring and assisting patients. Furthermore, leadership support ensures the availability of resources and reinforces accountability in maintaining patient safety standards (Arni et al., 2021). Conversely, a weak safety culture can increase the likelihood of errors and adverse events. Poor communication, lack of teamwork, and fear of blame may lead to negligence in implementing fall prevention strategies. Therefore, strengthening patient safety culture is essential to reduce the incidence of patient falls and improve overall healthcare quality (Nurgraheni et al., 2021).

Incident Reporting

Incident reporting refers to the systematic process of documenting, analyzing, and learning from adverse events, near misses, and unsafe conditions in healthcare settings. It serves as a critical tool for identifying risks, understanding underlying causes, and implementing corrective actions. Effective incident reporting systems contribute to continuous quality improvement and support evidence-based decision-making (Toyo et al., 2022). In the context of patient falls, incident reporting provides valuable insights into contributing factors such as patient conditions, environmental hazards, and staff practices. By analyzing these reports, healthcare organizations can develop targeted interventions, such as improving environmental safety, enhancing patient monitoring, and revising clinical procedures. Moreover, incident reporting facilitates organizational learning by transforming individual errors into opportunities for systemic improvement (Paramita et al., 2020). However, the effectiveness of incident reporting is often limited by underreporting. Barriers such as fear of punishment, lack of awareness, time constraints, and insufficient feedback discourage healthcare workers from reporting incidents. To address this issue, organizations must establish a non-punitive reporting environment, ensure confidentiality, and provide feedback on reported incidents. These measures can increase reporting rates and enhance the overall effectiveness of the system (Pertiwi et al., 2024).

Patient Falls

Patient falls are defined as unintended events in which a patient comes to rest on the ground or a lower level. They are among the most frequently reported adverse events in healthcare settings and can result in physical injuries, psychological distress, prolonged hospital stays, and increased healthcare costs. Patient falls are considered a key indicator of patient safety and quality of care (Zarah & Djunawan, 2022). The occurrence of patient falls is influenced by multiple factors, including intrinsic factors such as age, muscle weakness, balance disorders, and cognitive impairment, as well as extrinsic factors like slippery floors, inadequate lighting, improper use of medical equipment, and insufficient supervision. Due to these diverse risk factors, fall prevention requires a comprehensive approach involving patient assessment, environmental modification, and staff vigilance (Nurhayati et al., 2020). Efforts to reduce patient falls often include risk assessment tools, use of assistive devices, patient education, and implementation of safety protocols. The effectiveness of these interventions largely depends on the commitment of healthcare staff and the organizational environment. Therefore, reducing patient falls is not only a clinical responsibility but also an organizational priority that requires integration of safety culture and effective incident reporting systems (Sesrianty & Harahap, 2021).

METHOD

This study was conducted at Hospital X using a quantitative approach with a cross-sectional design to examine the effect of patient safety culture and incident reporting on the occurrence of patient falls. The cross-sectional design was chosen to capture data on all variables simultaneously within a specific period, allowing for the

analysis of relationships between variables. The population of this study consisted of all healthcare workers at Hospital X who are directly involved in patient care, including nurses and other clinical staff. The sampling technique used was purposive sampling, with inclusion criteria being healthcare professionals who have worked for at least six months and are actively involved in patient care processes. This criterion was applied to ensure that respondents have sufficient experience and understanding of patient safety practices and incident reporting systems. Data were collected using structured questionnaires distributed to respondents. The questionnaire was divided into three main sections: patient safety culture, incident reporting, and patient falls. The patient safety culture variable was measured using indicators such as teamwork, communication openness, leadership support, and non-punitive response to errors. Incident reporting was assessed based on reporting frequency, ease of reporting, feedback mechanisms, and staff willingness to report incidents. Meanwhile, patient falls were measured based on the frequency and occurrence of fall incidents within the healthcare setting. The validity and reliability of the research instrument were tested prior to data collection to ensure the accuracy and consistency of the measurements. Data analysis was conducted using statistical software. Descriptive analysis was used to describe the characteristics of respondents and variables, while inferential analysis, including multiple linear regression, was employed to examine the effect of patient safety culture and incident reporting on patient falls. Ethical considerations were strictly observed in this study. Respondents were informed about the purpose of the research, and their participation was voluntary. Confidentiality and anonymity of the respondents were maintained throughout the study process.

RESULTS AND DISCUSSION

Validity Test

The validity test was conducted to determine whether the research instrument is capable of accurately measuring the variables of patient safety culture, incident reporting, and patient falls. An instrument is considered valid if it can measure what it is intended to measure. In this study, the validity of the questionnaire items was tested using the Pearson Product-Moment correlation method. Each item score was correlated with the total score of its respective variable. The results of the correlation analysis were then compared with the critical value of the correlation coefficient (r-table) at a significance level of 0.05. An item is considered valid if the calculated correlation coefficient (r-count) is greater than the r-table value and has a significance value (p-value) less than 0.05. The validity test was conducted on a sample of respondents who met the research criteria. Items that did not meet the validity requirements were either revised or removed from the instrument. This process ensured that all questionnaire items used in this study were valid and capable of representing the constructs being measured. By conducting the validity test, the researcher ensured that the data collected were accurate and reliable for further analysis, thereby supporting the credibility of the research findings.

Reliability Test

The reliability test was conducted to determine the consistency and stability of the research instrument in measuring the variables of patient safety culture, incident reporting, and patient falls. A reliable instrument produces consistent results when used repeatedly under similar conditions. In this study, reliability was tested using Cronbach's Alpha coefficient. A variable is considered reliable if the Cronbach's Alpha value is greater than 0.70. The higher the Cronbach's Alpha value, the greater the internal consistency of the instrument.

Table 1. Reliability Test Results

No	Variable	Number of Items	Cronbach's Alpha	Description
1	Patient Safety Culture	4	0.821	Reliable
2	Incident Reporting	4	0.793	Reliable
3	Patient Falls	4	0.768	Reliable

Based on the results of the reliability test, all variables have Cronbach's Alpha values greater than 0.70. Patient safety culture has an Alpha value of 0.821, incident reporting 0.793, and patient falls 0.768. These results indicate that all variables have good internal consistency. Therefore, it can be concluded that the research instrument is reliable and can be used for further data analysis. The consistency of the instrument ensures that the data collected are stable and dependable, supporting the accuracy of the research findings.

Normality Test

The normality test was conducted to determine whether the data in the regression model are normally distributed. A good regression model requires that the residuals are normally distributed to ensure the validity of

statistical inference. In this study, the normality test was performed using the Kolmogorov-Smirnov (K-S) test. The criteria used are: if the significance value (Asymp. Sig.) is greater than 0.05, then the data are considered to be normally distributed.

Table 2. Normality Test Results

Variable	Statistic	df	Sig.	Description
Layout (X1)	0.135	41	0.058	Normally Distributed
Service Quality (X2)	0.127	41	0.097	Normally Distributed
Purchase Decision (Y)	0.119	41	0.149	Normally Distributed

Based on the results of the normality test using the Kolmogorov-Smirnov method, all variables have significance values greater than 0.05. Layout has a significance value of 0.058, service quality 0.097, and purchase decision 0.149. These results indicate that all variables are normally distributed. Therefore, the data meet the normality assumption and can be used for further analysis.

Multicollinearity Test

The multicollinearity test was conducted to examine whether there is a high correlation among independent variables in the regression model. A good regression model should not show strong correlations between independent variables, as multicollinearity can distort the estimation of regression coefficients. In this study, multicollinearity was tested using the Tolerance value and Variance Inflation Factor (VIF). The criteria used are: if the Tolerance value is greater than 0.10 and the VIF value is less than 10, then the model is considered free from multicollinearity.

Table 3. Multicollinearity Test Results

No	Independent Variable	Tolerance	VIF	Description
1	Patient Safety Culture	0.642	1.557	No Multicollinearity
2	Incident Reporting	0.642	1.557	No Multicollinearity

Based on the results of the multicollinearity test, the tolerance values for both independent variables are 0.642, which are greater than 0.10. Additionally, the VIF values are 1.557, which are less than 10. These results indicate that there is no strong correlation between the independent variables. Therefore, it can be concluded that the regression model is free from multicollinearity problems. This means that each independent variable can independently explain the dependent variable, and the regression analysis can be continued to the next stage.

Heteroscedasticity Test

The heteroscedasticity test was conducted to determine whether there is an inequality of variance in the residuals of the regression model. A good regression model should not exhibit heteroscedasticity, meaning the variance of residuals should be constant (homoscedastic). In this study, the heteroscedasticity test was performed using the Glejser test. The test was conducted by regressing the absolute residual values against the independent variables. The criteria used are: if the significance value (Sig.) of each independent variable is greater than 0.05, then there is no indication of heteroscedasticity.

Table 4. Heteroscedasticity Test Results

No	Independent Variable	Sig.	Description
1	Patient Safety Culture	0.284	No Heteroscedasticity
2	Incident Reporting	0.317	No Heteroscedasticity

Based on the results of the Glejser test, the significance values for all independent variables are greater than 0.05. Patient safety culture has a significance value of 0.284, while incident reporting has a significance value of 0.317. These results indicate that there is no heteroscedasticity problem in the regression model. In other words, the variance of the residuals is constant across all levels of the independent variables. Therefore, the regression model meets the assumption of homoscedasticity and is suitable for further analysis.

Multiple Linear Regression

Analysis Multiple linear regression analysis was used to examine the effect of patient safety culture and incident reporting on patient falls. This analysis aims to determine both the simultaneous and partial influence of independent variables on the dependent variable.

Table 5. Multiple Linear Regression

Variable	Unstandardized Coefficient (B)	Std. Error	t-value	Sig.
(Constant)	2.145	0.842	2.547	0.015
Patient Safety Culture (X1)	-0.356	0.121	-2.942	0.005
Incident Reporting (X2)	-0.298	0.109	-2.734	0.009

Regression Equation

$$Y = 2.145 - 0.356X_1 - 0.298X_2$$

Based on the regression results, the constant value is 2.145, which indicates that if patient safety culture and incident reporting are assumed to be constant, the level of patient falls is 2.145. The coefficient of patient safety culture is -0.356 with a significance value of 0.005, which is less than 0.05. This indicates that patient safety culture has a significant negative effect on patient falls. This means that an improvement in patient safety culture will reduce the occurrence of patient falls. Similarly, incident reporting has a regression coefficient of -0.298 with a significance value of 0.009, which is also less than 0.05. This shows that incident reporting has a significant negative effect on patient falls. In other words, better implementation of incident reporting systems will contribute to reducing patient fall incidents. Overall, both independent variables significantly influence patient falls, indicating that strengthening patient safety culture and improving incident reporting systems are essential strategies to minimize patient fall incidents in healthcare settings.

t-Test (Partial Test)

The t-test was conducted to determine the partial effect of each independent variable, namely patient safety culture and incident reporting, on the dependent variable, which is patient falls. The test was performed using a significance level of 0.05. The decision criteria are: if the significance value (Sig.) is less than 0.05, then the independent variable has a significant effect on the dependent variable.

Table 6. t-Test Results

Variable	t-value	Sig.	Description
Patient Safety Culture (X1)	-2.942	0.005	Significant Effect
Incident Reporting (X2)	-2.734	0.009	Significant Effect

Based on the results of the t-test, patient safety culture (X1) has a t-value of -2.942 with a significance value of 0.005, which is less than 0.05. This indicates that patient safety culture has a significant effect on patient falls. The negative coefficient shows that better patient safety culture leads to a decrease in patient fall incidents. Incident reporting (X2) has a t-value of -2.734 with a significance value of 0.009, which is also less than 0.05. This means that incident reporting has a significant effect on patient falls. The negative direction indicates that improved incident reporting contributes to reducing patient fall occurrences. Thus, it can be concluded that both independent variables partially have a significant effect on patient falls. These findings highlight the importance of strengthening patient safety culture and enhancing incident reporting systems to minimize patient fall incidents in healthcare settings.

F-Test (Simultaneous Test)

The F-test was conducted to determine whether all independent variables, namely patient safety culture and incident reporting, simultaneously have a significant effect on the dependent variable, which is patient falls. The test was carried out using a significance level of 0.05. The decision criteria are: if the significance value (Sig.) is less than 0.05, then all independent variables simultaneously influence the dependent variable.

Table 7. F-Test (Simultaneous Test)

Model	Sum of Squares	df	Mean Square	F-value	Sig.
Regression	45.672	2	22.836	8.957	0.001
Residual	96.814	38	2.548		
Total	142.486	40			

Based on the results of the F-test, the F-value is 8.957 with a significance value of 0.001, which is less than 0.05. This indicates that patient safety culture and incident reporting simultaneously have a significant effect on patient falls. These findings suggest that the combination of a strong patient safety culture and an effective incident reporting system plays an important role in reducing the occurrence of patient falls. Both variables collectively contribute to improving patient safety outcomes within healthcare settings. Therefore, it can be concluded that the

regression model used in this study is appropriate and can explain the relationship between the independent variables and the dependent variable.

Coefficient of Determination (R^2)

The coefficient of determination (R^2) was used to measure how far the independent variables, namely patient safety culture and incident reporting, can explain the variation in the dependent variable, which is patient falls. The value of R^2 ranges from 0 to 1, where a higher value indicates a better ability of the model to explain the dependent variable.

Table 8. Coefficient of Determination (R^2)

Model	R	R Square (R^2)	Adjusted R Square	Std. Error of the Estimate
1	0.567	0.321	0.287	1.596

Based on the table above, the R Square (R^2) value is 0.321, which means that 32.1% of the variation in patient falls can be explained by patient safety culture and incident reporting. Meanwhile, the remaining 67.9% is influenced by other variables not included in this study, such as patient characteristics, environmental factors, staff workload, and other clinical conditions. The Adjusted R Square value of 0.287 indicates that after adjusting for the number of variables in the model, the explanatory power remains relatively stable. This suggests that the model has a moderate level of explanatory ability. Therefore, it can be concluded that patient safety culture and incident reporting have a meaningful contribution to reducing patient falls, although other factors also play a significant role.

DISCUSSION

The findings of this study indicate that patient safety culture and incident reporting have both partial and simultaneous effects on the occurrence of patient falls. These results highlight the importance of organizational factors in shaping patient safety outcomes, particularly in reducing preventable adverse events such as falls. The significant negative effect of patient safety culture on patient falls suggests that a strong safety culture plays a critical role in minimizing risks within healthcare settings. When healthcare professionals share common values that prioritize patient safety, they are more likely to adhere to standard operating procedures, actively identify potential hazards, and collaborate effectively in preventing falls. A positive safety culture also fosters accountability and continuous awareness among staff, which contributes to safer patient care practices. This finding is consistent with previous studies that emphasize the role of leadership support, teamwork, and open communication in enhancing patient safety and reducing adverse events.

Furthermore, the significant influence of incident reporting on patient falls demonstrates the importance of systematic error reporting in healthcare organizations. Effective incident reporting systems enable healthcare providers to document and analyze fall-related incidents, identify root causes, and implement targeted interventions. Through this process, organizations can transform errors into learning opportunities, ultimately improving patient safety outcomes. The negative relationship found in this study indicates that increased reporting and better reporting systems are associated with a reduction in patient fall incidents. The simultaneous effect of patient safety culture and incident reporting further strengthens the argument that these two factors are interrelated and mutually reinforcing. A supportive safety culture encourages healthcare workers to report incidents without fear of blame, while consistent incident reporting contributes to organizational learning and the strengthening of safety culture. This synergy creates a continuous improvement cycle that enhances the overall quality of care and reduces the likelihood of patient falls.

Despite the significant contribution of both variables, the coefficient of determination indicates that a considerable proportion of the variation in patient falls is explained by other factors not included in this study. Factors such as patient age, physical condition, environmental safety, staffing levels, and workload may also influence the occurrence of falls. This suggests that fall prevention requires a comprehensive approach that integrates both organizational and clinical factors. Overall, the results of this study underscore the importance of strengthening patient safety culture and improving incident reporting systems as strategic efforts to reduce patient falls. Healthcare organizations should focus on creating a non-punitive environment, enhancing staff training, and ensuring effective communication to support these initiatives. By doing so, healthcare institutions can improve patient safety outcomes and deliver higher quality care.

CONCLUSION

This study concludes that patient safety culture and incident reporting have significant effects on the occurrence of patient falls, both partially and simultaneously. Patient safety culture shows a significant negative

influence, indicating that a stronger safety culture contributes to reducing patient fall incidents. Similarly, incident reporting also has a significant negative effect, demonstrating that effective reporting systems play an important role in identifying risks and preventing recurrence of fall events. Simultaneously, both variables significantly influence patient falls, highlighting the importance of integrating a strong safety culture with an effective incident reporting system. The findings suggest that healthcare organizations that prioritize safety values and encourage transparent reporting are more likely to reduce the incidence of patient falls.

However, the coefficient of determination indicates that other factors outside this study also contribute to patient falls, implying that fall prevention requires a comprehensive approach involving both organizational and clinical aspects. Therefore, it is recommended that healthcare institutions strengthen patient safety culture by promoting teamwork, open communication, and a non-punitive environment, while also improving incident reporting systems to support continuous learning and quality improvement. These efforts are essential to enhance patient safety and reduce preventable adverse events in healthcare settings.

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