

ORIGINAL ARTICLE

Government Hospital Nurses' Perspectives on Patient Safety Culture

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ABSTRACT

Introduction: A patient safety culture is essential for healthcare providers to deliver safe, quality patient care. Inadequate levels of patient safety culture are linked to many significant medical errors in hospital settings. This study will determine nurses' perceptions of patient safety culture in a government hospital. **Method:** A survey using the Hospital Survey on Patient Safety Culture to assess nurses' patient safety culture perception in a government hospital. **Results:** The total mean score for patient safety culture was $46.67 \text{SD} \pm 14.21$. The highest score was "Organisational learning—continuous improvement," and the lowest was "Non-punitive response to errors," with 78.4% and 11.6%, respectively. **Conclusion:** The average patient safety culture score was below 50%, which is lower than in other countries. The lowest score in the "Non-punitive response to errors" indicates that hospital management needed to overhaul the error reporting system to foster an efficient, blame-free, and professional environment, thereby reducing nurses' fear of reporting errors.

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INTRODUCTION

A safety culture enhances patient care by fostering a safety culture among healthcare practitioners. It encompasses healthcare workers' skills, attitudes, behaviours, and values to maximise workplace safety (1). Patient safety culture is a multidimensional framework designed to prevent and minimise patient harm (1). Given the positive correlation between safety culture factors and safety outcomes, it is imperative to instill a strong patient safety culture among nurses (2).

Nurses provide continuous patient care and safeguard patients' safety in hospitals. Therefore, a patient safety culture must be established in nurses' working environments, encouraging and firm to ensure patient safety, particularly in Malaysian hospitals (3). Given nurses' daily role in ensuring patient safety, they must

embrace and prioritise patient safety culture in everyday nursing practice (4).

While most studies on this topic were conducted in China, Lebanon, and Sweden, participants were commonly asked about various patient safety cultures. For instance, in Swedish hospitals, the highest scores are "teamwork within the unit" and "nonpunitive response to error" among healthcare practitioners (3). Similarly, the lowest scores were "staffing" and "management support for patient safety." The "organisational learning" and "teamwork within units" scored highest, whereas "nonpunitive response to error" and "staffing" were rated lowest reported in China (5). Likewise, "teamwork within the unit" received the highest ratings in Lebanese hospitals, while the lowest was "nonpunitive response to error."

It is evident that in Malaysia, studies on healthcare practitioners' patient safety culture are scarce. Two studies focused primarily on pharmacists' perceptions of patient safety culture, and these studies reported that perceptions related to "staff training and skills" and "working conditions" were the highest among

pharmacists in Malaysia (6, 7). However, studies on Malaysian nurses' perceptions of patient safety cultures are limited. One study in a private hospital examined private nurses' perceptions of patient safety culture about adverse events (8). However, this study only focuses on reported adverse events and total patient safety culture ratings (8). Nurses' perceptions of patient safety culture are essential in ward settings, where nurses are always with patients. Thus, baseline information regarding patient safety culture among nurses is required. This study aims to fill this gap by providing baseline data about patient safety culture perception among nurses using a validated tool. This study will reveal the barriers and challenges nurses face during their practice. Subsequently, the findings can be utilised to develop interventions that create more conducive working environments and a safe culture. Therefore, the objective is to describe the perceptions of patient safety culture among nurses in a government hospital and assess the frequency of reported safety events.

The conceptual framework for this study explores the relationship between independent variables, such as the characteristics of participants and the twelve domains of patient safety culture, and dependent variables, including "perceptions of patient safety culture" and "frequency of events reported." The overall perceptions of patient safety culture represent healthcare workers' general attitudes toward safety within their hospital. At the same time, the frequency of events reported captures how often safety incidents or adverse events are disclosed. Both outcomes are crucial indicators of how well a hospital's safety culture supports patient care and transparency in reporting potential issues. A positive safety culture would likely encourage higher event reporting and more favourable perceptions of safety practices.

The independent variables include the clinical characteristics of the participants, such as years of experience, job role, and specific work environment, alongside the twelve domains of patient safety culture. These domains typically involve teamwork, communication openness, leadership support for safety, and organisational learning from mistakes. The framework hypothesises that individual-level factors (clinical characteristics) and hospital-level factors (the twelve domains) will influence the dependent variables. This conceptual framework provides a structured means of investigating how a combination of personal attributes and institutional factors shape nurses' views on safety culture and their propensity to report adverse events, ultimately helping identify areas for improvement in hospital safety practices.

MATERIALS AND METHODS

This study used a cross-sectional survey design. It selected a government hospital in the southern region

of Peninsular Malaysia, which has over 550 in-patient beds and approximately 794 nurses. Data collection commenced after the Malaysian Ministry of Health Ethics and Medical Research Committee received ethical approval, with approval number NMRR-17-2735-38971 (IIR).

All nurses, including staff nurses, community nurses, nursing managers (nursing sisters), senior nursing managers (nursing matrons), and nursing tutors. The inclusion criteria were as follows: (1) all registered nurses and community nurses working in this hospital, (2) proficiency in English, and (3) willingness to participate in the study. Nurses were recruited irrespective of their years of experience to ensure the representation of all nursing staff. The study's exclusion criteria include individuals who are not registered nurses or community nurses working in this Hospital, those who need help understanding English, or those who are unwilling to participate. Also, temporary staff, trainees, or those not currently employed at this hospital were excluded. The total number of nurses in this hospital during the study period was 794. The sample size for this study was calculated using the sample size formula for finite populations by Krejcie and Morgan (9). The final required sample size to represent a population of 794 was 260. Accounting for a 10% dropout rate, the final sample size was 286 participants.

Instrument

The Hospital Survey on Patient Safety Culture assessed nurses' perceptions of safety culture (10). This well-established instrument has been used to measure safety culture in various settings (11). It is designated as a public document, and its use does not require permission or a license. It was tested in Malaysia and deemed suitable for use in the local context (12). A Cronbach's alpha score of 0.782 indicates that the instrument has good internal consistency, as it exceeds the 0.70 threshold. The Hospital Survey on Patient Safety Culture is a comprehensive tool consisting of 12 domains that cover a wide range of aspects related to patient safety culture, encompassing 42 items in total. The survey includes two questions that provide a holistic view of the respondents' perspective: one asks about the total grade for patient safety and the number of events reported for the past 12 months. Participants were required to provide demographic and clinical background information about their work area, position, and number of years working. Items in the Hospital Survey on Patient Safety Culture are rated on a five-point Likert scale ranging from "strongly agree" to "strongly disagree" or by frequency from "always to never." Positively and negatively worded items were included, and negatively worded items were reverse-coded during data analysis.

Before its implementation, a pre-test was conducted with 20 nurses who met the same inclusion and exclusion

criteria. This meticulous process minimised potential ambiguity or need for clarity in the questions, ensuring the reliability and validity of the Hospital Survey on Patient Safety Culture reliability and validity.

Data analysis

The descriptive statistics data analysis was conducted with SPSS version 25.0 to describe and determine hospital nurses' perceptions of safety culture, including frequencies and percentages of positive responses for each item and dimension. Frequencies counted the number of times specific responses appeared, providing a straightforward view of the data distribution. Percentages were used to compare positive responses across different items and dimensions, offering a clearer picture of overall trends and perceptions of safety culture within the hospital.

Data collection

The data collection process began with screening all eligible nurses from every unit and ward. Then, nurses from each unit were stratified based on the total number of nurses in the hospital. Potential subjects were randomly selected using Microsoft Office Excel. Subjects who agreed to participate were provided informed consent and a self-administered instrument.

RESULTS

Demographic Characteristics

A total of 286 nurses were invited to participate in the study. However, the optimal sample size for this study was 260. However, only 250 nurses participated in this study, resulting in a response rate of 87.4%. Table I illustrates the distribution of participants based on their respective working units. Out of the 250 participants, 79 (31.6%) were working in the acute setting (secondary care), while 171 (68.4%) were working in the non-acute setting and nursing management office. Most of the nurses in the non-acute setting were working in the medical ward (14.1%), followed by the surgical ward (12.8%) and paediatric ward (6.9%). Only two nurses (0.8%) worked in the nursing management office.

Table II illustrates the distribution of participants' working positions and the nature of their positions. Most of the participants were registered nurses (79.2%), followed by nursing managers (13.2%) and community nurses (6.4%). Regarding the nature of their positions, most participants reported having direct contact with patients (98.8%).

Sociodemographic characteristics

This study included 250 nurses working in the hospital. The sociodemographic backgrounds of the participants

Table I: Distribution of the sample based on working unit

Working Area	Frequency(%)
Acute setting	
Accident and emergency	6(2.4)
Labour room	12(4.8)
Operation theater	17(6.8)
Intensive care unit	16(6.4)
Neonatal intensive care unit	17(6.8)
Cardiac care unit and high dependency ward	11(4.5)
Non-acute setting and nursing management office	
Medical ward	35(14.1)
Surgical ward	32(12.8)
Pediatric ward	17(6.9)
Psychiatric ward	7(2.8)
Oncology ward	7(2.8)
First class ward	8(3.2)
Outpatients clinics	14(5.7)
Hemodialysis unit	10(4.0)
Orthopedic ward	9(3.6)
Obstetrics and gynecology ward	12(4.8)
Multidisciplinary ward	11(4.4)
Nursing college	7(2.8)
Nursing manager office	2(0.8)
Total	250(100)

Table II: Distribution of working position and nature of the position

Nursing position	Frequency (%)
Position	
Senior nursing manager (Matron)	3(1.2)
Nursing manager (Sister)	33(13.2)
Registered nurse	198(79.2)
Community nurse	16(6.4)
Position nature	
Direct contact with patients	247(98.8)
No direct contact with patients	3(1.2)

are presented in Table III. The mean age of the sample was 36.2SD±7.89, with the majority falling between the ages of 31 and 40 (42.4%). Regarding gender, most were women (96.8%), and the vast majority were Malay (99.6%). Most participants had received education up to the diploma level (87.2%).

Table IV illustrates the distribution of participants based on their working experience. The mean number of years working in the current hospital was 9.6SD±6.72 years, with most participants having worked 0-5 years at the current hospital (38.4%). The mean number of years working in the current unit was 6.1SD±5.34 years, and most participants had worked 0-5 years in the current unit (63.2%). The mean number of years working as a nurse was 11.9SD±7.28 years, with most participants working for 6-10 years (26.8%).

Table III: Sociodemographic Characteristics

Demographics	Mean±SD	Frequency(%)
Age (years)	36.2±7.9	
21 to 30		71(28.4)
31 to 40		106(42.4)
41 to 50		61(24.4)
51 to 60		12(4.8)
Gender		
Men		8(3.2)
Women		242(96.8)
Ethnicity		
Malay		249(99.6)
Indian		0.4(0.4)
Education level		
Certificate		20 (8.0)
Diploma		218 (87.2)
Degree and above		12(4.8)

Table IV: Working Experience

Duration of working (Years)	Mean ± SD	Frequency (%)
Current hospital	9.6 ± 6.7	
0 – 5		96(38.4)
6 – 10		57(22.8)
11 – 15		45(18.0)
16 – 20		33(13.2)
21 – 25		14(5.6)
26 – 30		5(2.0)
Current unit	6.1 ± 5.3	
0 – 5		158(63.2)
6 – 10		50(20.0)
11 – 15		23(9.2)
16 – 20		13(5.2)
21 – 25		4(1.6)
26 – 30		2 (0.8)
As a nurse	11.9 ± 7.3	
0 – 5		60(24.0)
6 – 10		67(26.8)
11 – 15		48(19.2)
16 – 20		36(14.4)
21 – 25		27(10.8)
26 – 30		12(4.8)

Table V presents the participants' responses to items about patient safety culture. The three dimensions with the highest percentage of average positive responses were "organisational learning-continuous improvement" (78.4%), "teamwork within units" (74.3%), and "management support for patient safety" (61.2%). Meanwhile, the three dimensions with the lowest percentage of average positive responses were "non-punitive response to errors" (11.6%), "staffing" (19.5%), and "frequency of events reported" (33.3%). Additionally, the mean score of the total patient safety culture score was 46.67SD±14.21.

Table V: Responses to patient safety cultures items

Item	Strongly disagree/Disagree (n%)	Neither (n%)	Strongly agree/Agree (n%)	% Average Positive Respond
Teamwork within Units				74.3
People support one another in this unit.	12 (4.8)	46(18.4)	192(76.8)	76.8
When a lot of work need to be done quickly, we get the work done.	9(3.6)	39(15.6)	202(80.8)	80.8
In this unit, people treat each other with respect.	19(7.6)	57(22.8)	174(69.6)	69.6
When one area in this unit gets really busy,others help out	29(11.6)	46(18.4)	175(70.0)	70
Supervisor/Manager Expectations & Actions Promoting Patient Safety				48.6
My supervisor/manager says a good word when according to established patient safety procedures	26(10.4)	49(19.6)	175(70.0)	70
My supervisor/manager seriously considers staff suggestion for improving patient safety.	38(15.2)	55(22.0)	157(62.8)	62.8
Whenever pressure builds up, my supervisor/manager wants us to work faster, even if it means taking shortcuts. (R)	111(44.4)	68(27.2)	71(28.4)	44.4
My supervisor/manager overlooks patient safety problems that happen over and over. (R)	43(17.2)	63(25.2)	144(57.6)	17.2
Organizational Learning—Continuous Improvement				78.4
We are actively doing things to improve patient safety	10(4.0)	31(12.4)	209(83.6)	83.6
Mistakes have led to positive changes here.	18(7.2)	61(24.4)	171(68.4)	68.4
After we make changes to improve patient safety, we evaluate their effectiveness	6(2.4)	36(14.4)	208(83.2)	83.2
Management Support for Patient Safety				61.2
Hospital management provides a work climate that promotes patient safety.	14(5.6)	40(16)	196(78.4)	78.4
The actions of hospital management show that patient safety is a top priority.	13(5.2)	48(19.2)	189(75.6)	75.6
Hospital management seems interested in patient's safety only after an adverse event happens. (R)	74(29.6)	63(25.2)	113(45.2)	29.6
Feedback & Communication About Error				60.8
We are given feedback about changes put into place based on event reports.	42(16.8)	75(30.0)	133(53.2)	53.2
We are informed about errors that happen in this unit.	29(11.6)	56(22.4)	165(66.0)	66
In this unit, we discuss ways to prevent errors from happening again.	39(15.6)	53(21.2)	158(63.2)	63.2
Communication Openness				38.8
Staff will freely speak up if they see something that may negatively affect patient care	48(19.2)	102 (40.8)	100(40.0)	40
Staff feel free to question the decisions or actions of those with more authority.	50(20.0)	100 (40.0)	100(40.0)	40
Staff are afraid to ask questions when something does not seem right. (R)	91(36.4)	93(37.2)	66(26.4)	36.4
Teamwork Across Units				56.4
There is good cooperation among hospital units that need to work together.	28(11.2)	43(17.2)	179(71.6)	71.6
Hospital units work well together to provide the best care for patients.	32(12.8)	38(15.2)	180(72.0)	72
Hospital units do not coordinate well with each other. (R)	118(47.2)	67(26.8)	65(26.0)	47.2
It is often unpleasant to work with staff from other hospital units. (R)	87(34.8)	84(33.6)	79(31.6)	34.8

CONTINUE

Table V: Responses to patient safety cultures items (CONT.)

Staffing					19.5
We have enough staff to handle the workload.	112(44.8)	67(26.8)	69(27.6)	27.6	
Staff in this unit work longer hours than is best for patient care. (R)	32(12.8)	49(19.6)	169(67.6)	12.8	
We use more agency/temporary staff than is best for patient care. (R)	54(21.6)	88(35.2)	108(43.2)	21.6	
We work in "crisis mode" trying to do too much, too quickly. (R)	49(16.0)	65(26.0)	145(58)	16	
Handoffs & Transitions					34.4
Things "fall between the cracks" when transferring patients from one unit to another. (R)	71(28.4)	85(34.0)	94(37.6)	28.4	
Important patient care information is often lost during shift changes. (R)	100(40.0)	47(18.8)	103(41.2)	40	
Problems often occur in the exchange of information across hospital units. (R)	56(22.4)	98(39.2)	96(38.4)	22.4	
Shift changes are problematic for patients in this hospital. (R)	117(46.8)	41(16.4)	92(36.8)	46.8	
Nonpunitive Response to Errors					11.6
Staff feel like their mistakes are held against them. (R)	32(12.8)	81(32.4)	137(54.8)	12.8	
When an event is reported, it feels like the person is being written up, not the problem. (R)	37(14.8)	50(20.0)	163(65.2)	14.8	
Staff worry that mistakes they make are kept in their personnel file. (R)	18(7.2)	41(16.4)	191(76.4)	7.2	
Frequency of Events Reported					33.3
When a mistake is made, but is caught and corrected before affecting the patient, how often is this reported?	59(23.6)	105(42)	86(34.4)	34.4	
When a mistake is made but have no potential to harm the patient, but does not, how often is this reported?	60(24.0)	108(43.2)	82(32.8)	32.8	
When a mistake is made that could harm the patient, but does not, how often is this reported?	67(26.8)	101(40.4)	82(32.8)	32.8	
Overall Perceptions of Patient Safety					42.8
Patient safety is never sacrificed to get more work done.	33(13.2)	78(31.2)	139(55.6)	55.6	
Our procedures and systems are good at preventing errors from happening.	27(10.8)	34(13.6)	189(75.6)	75.6	
It is just by chance that more serious mistakes don't happen around here. (R)	23(9.2)	73(31.6)	189(75.6)	9.2	
We have patient safety problems in this unit. (R)	77(30.8)	62(24.8)	111(44.4)	30.8	
Mean $\pm$ SD for total score = 46.7 $\pm$ 14.21					

Note: R = reverse item

Table VI presents the distribution of participants' self-perceived Safety Culture. Most of the participants graded the level of patient safety in this hospital as "acceptable" (64.0%), while 67 participants (26.8%) graded it as "very good," and 5 perceived the grade as "excellent" (2.0%). Only one participant graded patient safety in this hospital as "failing" (0.4%).

Table VII presents the distribution of the number of events reported by the participants in the past 12 months. More than half (69.6%) reported that they did not report any events. Forty-two participants (16.8%) reported only one event, while three (1.2%) and two (0.8%) reported four and five events, respectively.

Table VI: Perceived patient safety grade

Category	Frequency (%)
Excellent	5(2.0)
Very good	67 (26.8)
Acceptable	169 (64.0)
Poor	17 (6.8)
Failing	1 (0.4)

Table VII: Number of the events reported by the sample

Number of events reported	Frequency (n)	Percentage (%)
0	174	69.6
1	42	16.8
2	19	7.6
3	10	4.0
4	3	1.2
5	2	0.8
Total	250	100

DISCUSSION

The present study found that the mean total patient safety culture score was 46.67 ± 14.21 . Previous overseas studies by Azmal et al. (12) reported that Iranian nurses' mean overall patient safety culture score was 55.0. In contrast, Nie et al. (13) reported that the mean total patient safety culture score among Chinese nurses was 65.0. In the local context, a recent study by Alex Kim et al. (14) reported a mean positive response of 50.1%. A database report from the AHRQ involving 382,834 healthcare providers revealed that the average percentage positive for all dimensions was 65%. These comparisons show that the overall positive response in this study is lower than in studies conducted in other countries.

The positive responses to safety culture ranged from 11.6% to 78.4%. Compared to previous overseas studies, Ammouri et al. (15) reported positive reactions to the 12 safety culture dimensions ranging from 21.4% to 83.4% among Jordanian nurses. In contrast, Nie et al. (13) reported that the positive responses to the 12 dimensions of safety culture ranged from 45% to 88% among Chinese nurses. Likewise, these findings showed that the safety culture among nurses in this hospital was lower than in previous studies that used the same tool.

This study also discovered that the highest score is "organisational learning—continuous improvement," followed by "teamwork within units" and "management support for patient safety," which achieved the highest three average percentage positive responses. In this hospital, Continuous Nurses Education (CNE) sessions are conducted every week, allowing nurses to learn new updates about clinical practice delivered by experts.

Moreover, nurses are also selected to join post-basic courses - a nursing specialised course organised by the Ministry of Health after several years of service. Additionally, Patient Safety Goals and guidelines on incident reporting and the learning system were introduced to all public hospitals throughout Malaysia in 2013. Thus, each department was trained as risk managers and encouraged to report patient safety incidents. This shows that management supports the implementation of a patient safety culture.

On the other hand, the three dimensions with the lowest average percentage of positive responses were “non-punitive response to errors,” “staffing,” and “frequency of events reported.” These findings align with a systematic review study on safety culture in the Arabian country, which reported that “organisational learning—continuous improvement” and “teamwork within units” were highly practised among Arabian nurses, whereas “staffing” and “non-punitive response to error” were the most problematic domains among them (16).

The least practised among nurses in this hospital was “Non-punitive response to error,” possibly due to a fear that reporting mistakes would be held against them, potentially tarnishing their career track record (14). Therefore, building a safety culture is necessary to create a blame-free, fear-free, and error-reporting environment in nurses’ workplaces (17). The domain of “staffing” was also problematic among respondents. This is a common concern regarding patient safety in other countries and Malaysia (14, 18). Inadequate staffing to meet the increasing workload can lead to fatigue and increase the risk of medical errors, causing adverse patient safety events (19). Staffing problems were observed in this hospital as some nurses were on maternity leave and others were selected to join post-basic courses, subsequently affecting the number of nurses on duty.

Regarding self-perceived patient safety grade, most respondents (64.0%) rated the level of patient safety grade as “acceptable.” This finding is comparable to those of Alex Kim et al. (14), who reported that 63.1% of the respondents rated the level of patient safety grade as “acceptable.” Additionally, the finding was consistent with the one reported by Azmal et al. (12), who found that most Iranian nurses also graded their working hospital’s culture as “acceptable.” However, only 30.4% of the respondents reported at least one event in the past 12 months, which is lower than in previous studies and AHRQ data, which found that over 40% reported at least one event in the past 12 months (14). This finding suggests strategies to increase the perception of safety culture for nurses to achieve a better patient safety grade level in this hospital.

Nevertheless, the findings were comparable to those of a study conducted by Azmal et al. (12), where most Iranian nurses reported “no event” in the past

12 months. However, the actual number of events in clinical settings was relatively high. Nurses report actual events at a lower level than the exact level, likely due to the harmful effects of reporting and possibly adverse reactions from managers and colleagues (20). Once again, the findings emphasise the need to establish an error reporting system and a non-punitive approach to reduce the number of errors and encourage nurses to report mistakes, creating an opportunity for others to learn and prevent misunderstandings.

The theoretical significance of this study lies in its contribution to the existing body of literature on safety culture and its impact on healthcare outcomes. By exploring nurses’ perspectives, the study enhances our understanding of the dynamics within healthcare teams and how these perceptions influence patient safety practices (21). This research addresses critical issues highlighted in the background, such as the need for a supportive environment that encourages reporting and learning from errors. Practically, the findings can inform targeted interventions to strengthen the patient safety culture within the hospital, guiding leadership in implementing policies that promote open communication, continuous education, and collaborative practice. By aligning theoretical insights with practical applications, this study provides a comprehensive framework for improving patient safety and quality of care in healthcare settings.

The results of this study underscore the need for a robust quality management policy within the hospital to enhance patient safety and care outcomes. By integrating findings into policy development, hospitals can establish standardised protocols that promote best practices in clinical care, streamline processes, and ensure accountability among staff (22, 23). Recommendations may include regular training sessions focused on quality improvement, implementing patient feedback mechanisms, and data-driven assessments to identify areas for enhancement. Such a comprehensive approach fosters a culture of continuous improvement and aligns organisational goals with the overarching mission of delivering safe, high-quality patient care.

Further recommendations for advancing this initiative include targeted training for nurses in private hospitals, where specific challenges and dynamics differ from public institutions (24). Engaging private sector nurses in safety culture initiatives can enhance collaboration and knowledge sharing across healthcare settings (25). Additionally, establishing partnerships with regulatory bodies and healthcare organisations can facilitate the implementation of best practices in patient safety. Ongoing evaluation and feedback mechanisms should be integrated into these training programs to ensure their effectiveness and adaptability, thereby promoting a sustainable culture of safety that aligns with the ever-evolving landscape of healthcare (26).

Limitations

Several study limitations need to be acknowledged. The respondents of this study are nurses working in only one government hospital. Therefore, the results cannot be generalised to nurses or healthcare professionals in other hospitals. Future studies could include nurses from other hospitals and other healthcare professionals, such as medical doctors, pharmacists, physiotherapists, and dietitians, to identify any differences in the findings due to different work settings and job scopes. This is a cross-sectional study; therefore, it cannot provide evidence for a causal relationship between independent and outcome variables. A longitudinal study can be conducted to validate this cross-sectional finding.

CONCLUSIONS

The mean score of the total safety culture score was less than 50% in this study, which is lower than that of studies in other countries. This study also found that the dimension of “non-punitive response to errors” received the lowest score. This indicates the need for the hospital’s management to revise the error reporting system to introduce an efficient, blame-free, and professional system to reduce nurses’ fear of reporting errors. Moreover, nurse managers should encourage nurses to report errors and help solve them professionally without introducing excessive fear and embarrassment. The nurses also felt that staffing is a significant problem in their workplaces, as in this study, hospital, medical, and surgical wards are considered “very busy” units, and more staff should be allocated to prevent errors. Hence, the hospital management needs to re-evaluate and reassess the staffing allocation of each work setting to prevent understaffing.

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