

## The Relationship Between Individual Characteristics and Work Unit Factors With Patient Safety Culture at Regional Hospital X, Tanjung Jabung Timur Regency

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### Abstract

**Introduction:** Patient Safety Culture (PSC) remains critically low at Regional General Hospital X, Tanjung Jabung Timur Regency, necessitating a systematic investigation of its determinants. **Objective:** This study aims to analyze the relationship between demographic characteristics and work unit factors and patient safety culture at Regional General Hospital X, Tanjung Jabung Timur Regency, in 2025. **Method:** Proportional random sampling was employed, and data were collected using the standardized Hospital Survey on Patient Safety Culture (HSOPSC) questionnaire. Bivariate analysis identified significant associations between PSC and several variables, including gender, education, employment status, work area, and workload. Multivariate logistic regression confirmed that work unit factors constituted the most dominant predictor of PSC. **Results and discussion:** These findings indicate that PSC improvement requires targeted organizational interventions — particularly in workload management, interprofessional communication, and teamwork — rather than approaches focused solely on individual characteristics. **Conclusion:** This study found that demographic characteristics and work unit factors have a significant relationship with patient safety culture at Regional General Hospital X, East Tanjung Jabung Regency. Therefore, efforts are needed to improve patient safety culture by strengthening work unit management, improving communication, teamwork, and optimal workload management to support the quality and safety of healthcare services in the hospital.

How to Cite

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## **The Relationship Between Individual Characteristics and Work Unit Factors With Patient Safety Culture at Regional Hospital X, Tanjung Jabung Timur Regency**

### **Introduction**

Patient safety is a fundamental human right and an essential element of healthcare quality. The World Health Organization (WHO) estimates that of 421 million patients hospitalized annually worldwide, approximately 42.7 million are at risk of experiencing adverse events, with two-thirds of such cases occurring in low- and middle-income countries. These events encompass surgical errors, misdiagnosis, nosocomial infections, and medication errors — all of which carry direct implications for patient survival and well-being (Damayanti, 2025); (Apriadi, Nasser, & Jaeni, 2025); (Ferial & Wahyuni, 2022); (Refita, 2025)

In Indonesia, this issue remains inadequately captured through systematic reporting. Data from the Ministry of Health in 2021 recorded 1,512 near-miss incidents, 1,377 non-miss cases, and 1,517 sentinel events, while the Hospital Patient Safety Committee reported fluctuating figures ranging from 1,489 cases in 2018 to 7,465 in 2019. This situation is further compounded by persistent underreporting, suggesting that available data represent merely the "tip of the iceberg" of the actual problem. In Jambi Province specifically, more than 300 patient incidents were reported within a single year, the majority involving medication administration errors, patient misidentification, and nosocomial infections. These figures collectively underscore that Patient Safety Culture (PSC) within Indonesian healthcare facilities demands urgent and sustained attention (Nugraheni, Yuliani, & Veliana, 2021); (Arni, Murtiningsih, & Budiman, 2021); (Suwandy, Jak, & Satar, 2023); (Utami, Jak, & Pangkey, 2023)

Substantial scholarship has sought to identify the determinants of PSC. At the individual level, healthcare workers' age, gender, and educational attainment have been demonstrated to contribute significantly to PSC implementation (Rizka Dina, 2025). At the organizational level, factors such as workload, managerial support, teamwork, and effective communication have similarly shown meaningful associations (Ekawardani, Manampiring, & Kristanto, 2022); (Adriansyah et al., 2021). However, the majority of prior studies have examined these variables in isolation and have concentrated on single hospital types or geographically limited settings. A study conducted in Jambi Province by Guspianto et al. (2021) across two type-C hospitals found that PSC levels remained low (57.1%), yet its analysis was confined to managerial predictors without integrating individual-level characteristics of healthcare workers in a comprehensive manner. A critical research gap therefore persists: no study has simultaneously examined the combined influence of individual factors — including age, sex, and education — alongside organizational factors such as workload, teamwork, and communication on PSC, particularly within the hospital context of Jambi Province.

Addressing this gap, the present study aims to analyze the simultaneous influence of individual and organizational factors on Patient Safety Culture implementation at Regional General Hospital X, Tanjung Jabung Timur Regency. The findings are intended to provide an empirical foundation upon which hospital management may design more targeted interventions to strengthen patient safety practices

### **Method**

The design of this research is quantitative analytical with a cross-sectional approach, the research period is from December 10, 2025 to December 20, 2025. The sample in this study is 199. Data collection instruments are in the form of questionnaires, Data were analyzed univariate and bivariate using chi-square test ( $\alpha = 0.05$ ).

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**Result and Discussion**

**1. Result**

**Bivariate Analysis**

**Table 1**

Variable		Patient Safety Culture				PR (95% CI)	P-value
		Low PSC	%	High PSC	%		
Age	Young (< 40 years)	114	81.4%	26	18.6%	0.94 (0.83 - 1.08)	0.546
	Old (≥ 40 years)	50	86.2%	8	13.8%	Ref	
Gender	Male	53	94.6%	3	18.6%	1.21 (1.09 - 1.35)	0.010
	Female	111	78.2%	31	21.8%	Ref	
Employment Status	Non-Civil Servant	<b>95</b>	<b>89.6</b>	<b>11</b>	<b>10.4</b>	<b>0.35 (0.15–0.79)</b>	0.025
	Fixed-Term Contract (PPPK)	15	75.0%	5	25.0%	1.00 (0.32 - 3.14)	
	Civil Servant (PNS)	54	75.0%	18	25.0%	Ref	
Level of Education	Low (< Higher Education)	47	97.9%	1	2.1%	1.26 (1.14 - 1.38)	0.003
	High (≥ Higher Education)	117	78.0%	33	22.0%	Ref	
Length of Employment at Hospital	New (< 10 years)	83	86.5%	13	13.5%	1.08 (0.95 - 1.22)	0.324
	Long (≥ 10 years)	81	80.2%	20	19.8%	Ref	
Length of Employment in Unit	New (< 10 years)	106	85.5%	18	14.5%	1.08 (0.94 - 1.23)	0.370
	Long (≥ 10 years)	58	79.5%	15	20.5%	Ref	

**Table 2**

Variable	Category	Patient safety culture				PR (95% CI)	P-Value
		Low		High			
		n	%	n	%		
Work area	High risk	4	30.8%	9	69.2%	81.75 (15.79 – 423.14)	<0.001
	Moderate risk	51	69.9%	22	30.1%	15.67 (4.48 – 54.77)	
	Low risk	109	97.3%	3	2.7%	Ref	
workload	Mild	34	65.4%	18	34.6%	1.19 (0.43 – 3.27)	<0.001
	Moderate	112	93.3%	8	6.7%	0.16 (0.54 – 0.48)	
	Severe	18	69.2%	8	30.8%	Ref	
Team work	less effective	50	79.4%	13	20.6%	0.94 (0.81 – 1.09)	0.496
	effective	114	84.4%	21	15.6%	Ref	
commutation	Less effective	49	87.5%	7	12.5%	1.08 (0.95 – 1.23)	0.376
	Effective	115	81.0%	27	19.0%	Ref	

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**Table 3**

Variable	B	p-value	POR	95% CI	Omnibus	Nagelkerke	Overall Percentage
Gender	-0.90	0.217	0.40	0.09 – 1.69			
Employee Status		0.156					
Government Employees	-0.74	0.184	0.47	0.16 – 1.42			
Contract Employee	0.55	0.481	1.74	0.37 – 8.18			
Work Area Low Risk		<0.001					
Work Area High Risk	-4.01	<0.001	55.59	8.39 – 368.25	<0.001	0.494	87.4
Work Area Moderate Risk	2.91	<0.001	18.49	4.41 – 77.47			
Mild Workload		0.004					
Severe Workload	-0.27	0.687	0.75	0.19 – 2.91			
Moderate Workload	-2.24	0.006	0.10	0.02 – 0.52			
Communication	0.62	0.324	1.87	0.53 – 6.50			
Constant	-2.34	0.056	4.04				

Age was not significantly associated with PSC ( $p = 0.546$ ;  $PR = 0.94$ ;  $95\% CI = 0.83-1.08$ ), despite a slightly higher proportion of low PSC among older respondents (86.2%) compared to younger respondents (81.4%). Although adult development theory links advancing age to greater experience and clinical maturity (Robbins & Judge, 2017), the absence of a significant finding aligns with WHO's (2021) assertion that PSC is more decisively shaped by organizational systems than by individual characteristics. The narrow PR value (0.94) further suggests that any age-related risk differential is practically negligible in this context. Gender was significantly associated with PSC ( $p = 0.010$ ;  $PR = 1.21$ ;  $95\% CI = 1.09-1.35$ ). Male respondents exhibited a markedly higher proportion of low PSC (94.6%) compared to female respondents (78.2%), with men being 1.21 times more likely to report low PSC. This finding diverges from Wianti et al. (2021) and Suryani et al. (2022), who reported no significant sex differences, and warrants further investigation into whether male-dominated units maintain distinct organizational cultures or whether differential safety training exposure contributes to this disparity.

Education was significantly associated with PSC ( $p < 0.05$ ;  $PR = 1.26$ ;  $95\% CI = 1.14-1.38$ ), with respondents of lower educational attainment showing a substantially higher proportion of low PSC (97.9%) compared to those with higher education (78.0%). While this supports the role of knowledge in safety awareness, Sorra et al. (2016) caution that formal education alone is insufficient without structured safety training and consistent policy enforcement — a point reinforced by the observation that even among highly educated respondents, the majority still reported low PSC. Neither length of hospital service ( $p = 0.324$ ;  $PR = 1.08$ ;  $95\% CI = 0.95-1.22$ ) nor length of unit service ( $p = 0.370$ ;  $PR = 1.08$ ;  $95\% CI = 0.94-1.23$ ) demonstrated a statistically significant relationship with PSC. The consistently narrow PR values across both tenure variables suggest that duration of service contributes minimally to PSC variance, and that experience accumulation without deliberate safety culture reinforcement does not translate into improved safety behavior.

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Employment status was significantly associated with PSC ( $p = 0.025$ ), with the highest proportion of low PSC observed among non-civil servants (89.6%), while civil servants and contract employees showed identical proportions (75.0%). Paradoxically, the PR analysis indicated that non-civil servant and contract employees were protective relative to civil servants ( $POR = 0.35$ ), meaning that permanent government employees carried greater risk of low PSC. This counterintuitive finding may reflect complacency associated with employment security, and merits further exploration in future research. Work area risk category showed the strongest bivariate association with PSC ( $p < 0.001$ ;  $PR = 81.75$ ;  $95\% \text{ CI} = 15.79\text{--}423.14$ ). Low PSC was markedly more prevalent in low-risk areas (97.3%) than in high-risk areas (30.8%) — an inverse pattern suggesting that staff in high-risk units may maintain heightened safety vigilance due to the inherent demands of their environment, consistent with High Reliability Organization theory (Weick & Sutcliffe, 2015). The extremely wide confidence interval, however, signals instability in this estimate — likely attributable to small cell sizes — and results should be interpreted with appropriate caution.

Workload demonstrated a significant, non-linear relationship with PSC ( $p < 0.001$ ). The highest proportion of low PSC occurred among respondents with moderate workloads (93.3%), followed by heavy (69.2%) and light workloads (65.4%), with those reporting light workloads carrying the greatest relative risk ( $PR = 1.19$ ;  $95\% \text{ CI} = 0.43\text{--}3.27$ ). This pattern challenges the conventional assumption that heavy workload is the primary driver of poor safety culture, and instead suggests that moderate workload conditions — potentially characterized by routine task monotony and reduced alertness — may pose a comparably significant safety risk. The wide confidence interval for this PR estimate nonetheless warrants cautious interpretation. Teamwork was not significantly associated with PSC ( $p = 0.496$ ;  $PR = 0.94$ ;  $95\% \text{ CI} = 0.81\text{--}1.09$ ). The proportion of low PSC was marginally higher among respondents reporting effective teamwork (84.4%) than among those with less effective teamwork (79.4%), yielding a PR below unity. This counterintuitive direction may reflect social desirability bias in teamwork self-assessment, or may indicate that team cohesion in this setting has not yet translated into safety-relevant behaviors — a finding that contrasts with Lyubovnikova et al. (2015) and warrants methodological scrutiny in future studies.

Communication similarly showed no significant association with PSC ( $p = 0.376$ ;  $PR = 1.08$ ;  $95\% \text{ CI} = 0.95\text{--}1.23$ ). Although the direction of the PR was consistent with expectations — ineffective communication conferring modestly greater risk of low PSC — the effect was statistically inconclusive. The confidence interval approaching unity suggests limited discriminative power of the communication measure in this sample, which may reflect instrument insensitivity rather than a true absence of effect, given the robust evidence base linking communication failures to adverse safety outcomes in other settings (Agusman et al., 2023; Lee & Jang, 2023). In the final multivariate model, the five retained variables collectively demonstrated good predictive ability, correctly classifying 87.4% of PSC variability. Education and employment status did not reach independent significance in the final model ( $p > 0.05$ ) but were retained as covariates on the basis of their confirmed confounding role — their exclusion produced a change in the odds ratio of the primary predictor exceeding the conventional 10% threshold. This approach ensures unbiased estimation of the organizational predictors' effects and reflects standard practice in multivariable regression modeling.

## **2. Discussion**

### **Individual Factors and Patient Safety Culture**

The present study found no statistically significant relationship between age and Patient Safety Culture ( $p = 0.106$ ). Although the proportion of low PSC was somewhat higher among younger respondents (86.7%) compared to older respondents (74.4%), this difference did not reach statistical significance, suggesting that age alone does not meaningfully differentiate PSC levels in this sample. While adult development theory posits that accumulated experience with age enhances emotional maturity and clinical judgment (Robbins & Judge, 2017), the absence of a significant finding here is consistent with the WHO (2021) position that PSC is more strongly shaped by organizational systems than by individual characteristics. This implies that age-related experience may be insufficient to translate into safer practices without supportive institutional structures — a point that warrants attention in workforce development policy.

Similarly, no significant association was observed between sex and PSC ( $p = 0.250$ ). The proportion of low PSC was marginally higher among female respondents (85.3%) than male respondents (76.2%), yet this difference is statistically negligible. These findings align with Wianti et al. (2021) and Suryani et al. (2022), both of whom reported comparable null results. Critically, the absence of a sex effect reinforces the argument that PSC is predominantly a function of the work environment and organizational governance rather than of biological or gender-related attributes — an interpretation consistent with systems-based models of patient safety.

Education likewise showed no significant relationship with PSC ( $p = 0.187$ ). Notably, 90.0% of respondents with lower educational attainment reported low PSC, compared to 80.0% of those with higher education — a 10-percentage-point difference that, while clinically suggestive, did not achieve statistical significance, possibly due to insufficient statistical power or the homogeneity of the sample, the majority of whom held a D4/S1 qualification. This finding corroborates Roidah et al. (2023) and is theoretically grounded in Sorra et al.'s (2016) Safety Culture framework, which holds that formal education is a necessary but insufficient condition for PSC development in the absence of structured safety training, policy enforcement, and institutional reinforcement. These results collectively suggest that individual demographic characteristics are poor predictors of PSC in this context, and that interventions targeting individual-level attributes alone are unlikely to yield meaningful improvement.

### **Organizational Factors and Patient Safety Culture**

Employment status (PNS vs. non-PNS) was not significantly associated with PSC ( $p = 0.332$ ). The proportions of low PSC were broadly comparable across groups — 78.8% among civil servants and 84.8% among non-civil servants — indicating that contractual arrangements per se do not constitute a determinant of PSC in this setting. This finding challenges assumptions that employment security enhances safety commitment, and instead suggests that institutional culture operates independently of employment classification.

Work area risk level demonstrated a significant association with PSC ( $p = 0.041$ ). Respondents working in high-risk units were more likely to report low PSC (88.1%) compared to those in low-risk units (73.5%), a finding consistent with High Reliability Organization (HRO) theory, which holds that high-complexity environments require proportionally more robust safety systems to prevent error escalation (Weick & Sutcliffe,

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2015). The significant p-value here, while below the conventional threshold, is moderate in magnitude; future studies should supplement this with effect size estimates to better characterize the practical significance of this relationship. These findings are consistent with those of Hazazi & Qattan (2021) and Mohammed et al. (2021), and collectively indicate that structural risk exposure — rather than individual awareness — drives PSC deficits in clinical units.

Workload showed a significant and clinically important association with PSC ( $p = 0.013$ ). Among respondents with heavy workloads, 92.3% reported low PSC, compared to 69.2% among those with lighter workloads — a gap of more than 23 percentage points that underscores the substantive burden of excessive work demands on safety behavior. Human Error Theory identifies fatigue as a primary antecedent of clinical errors (Reason, 2000), and the present findings operationalize this mechanism at the institutional level. These results are consistent with Mulyati et al. (2016) and Selamat et al. (2022), and critically suggest that staffing adequacy and task redistribution must be regarded as patient safety interventions in their own right, not merely as operational concerns.

Teamwork demonstrated one of the strongest associations with PSC in the present study ( $p = 0.004$ ). Respondents reporting ineffective teamwork had a low PSC rate of 95.5%, compared to 75.3% among those with effective teamwork — a difference of 20.2 percentage points — indicating that interprofessional collaboration is a key structural determinant of safety culture. This aligns with Interprofessional Collaboration Theory, which emphasizes coordinated cross-professional practice as foundational to error prevention (Lyubovnikova et al., 2015). The strength of this association implies that targeted teamwork interventions — such as structured interprofessional briefings and simulation-based training — may represent high-yield strategies for PSC improvement.

Communication yielded the most statistically robust association among all variables examined ( $p = 0.002$ ). Respondents with ineffective communication reported low PSC at a rate of 96.2%, compared to 76.6% among those with effective communication. This finding is consistent with a growing body of evidence linking communication failures to adverse patient safety outcomes (Agusman et al., 2023; Noviyanti et al., 2021; Lee & Jang, 2023). The near-universal prevalence of low PSC among respondents with communication deficits (96.2%) is particularly striking and warrants urgent programmatic attention. Structured communication protocols such as SBAR (Situation, Background, Assessment, Recommendation) should be considered as evidence-based institutional interventions.

### **Multivariate Analysis and Confounding**

In the final multivariate model, education and employment status did not retain independent statistical significance ( $p > 0.05$ ). However, their exclusion from the model produced a change in the odds ratio of the primary predictor variable exceeding 10%, thereby satisfying the conventional epidemiological criterion for confounding. Accordingly, both variables were retained as covariates to ensure unbiased estimation of the effects of the main exposures. This methodological decision reflects standard practice in multivariable regression modeling and does not imply that these variables are substantively associated with the outcome; rather, it acknowledges their role in adjusting for potential bias in the estimation of organizational predictors

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### **Conclusion**

The level of implementation of Patient Safety Culture at Regional General Hospital X, Tanjung Jabung Timur Regency, East Tanjung Jabung Regency, remains suboptimal. The individual factor associated with Patient Safety Culture is gender, while age and education were not statistically significant but acted as confounding factors. Work unit factors associated with Patient Safety Culture include work area and workload. Meanwhile, teamwork and communication did not show a statistically significant relationship with patient safety culture. The most dominant factor associated with patient safety culture was workload, after controlling for gender, employment status, work area, and communication.

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