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Analysis of Determinant Factors Influencing Compliance with Patient Safety Incident Reporting Based on the Theory of Planned Behaviour

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Abstract:
Patient safety is a priority for healthcare services because it can lead to serious public health issues. Incident reporting is crucial for enhancing patient safety. This study aims to analyze the determinants of patient safety incident reporting compliance using the Theory of Planned Behavior. This study employed a cross-sectional design, with the population consisting of medical and nursing staff, involving 116 participants selected using a simple random sampling technique. The analysis in this study used Logistic regression analysis. The study found that health professionals reported high levels of bullying (56.9%), poor patient safety culture (75.0%), low protection motivation (53.4%), and non-compliance in reporting patient safety incidents (55.2%). Logistic regression analysis, which had the potential to comply with incident reporting, showed low bullying (aOR: 1.8; 95% CI: 0.69-4.81), good patient safety culture (aOR: 2.9; 95% CI: 0.93-9.25), and high protection motivation (aOR: 1.91; 95% CI: 0.86-4.25). The importance of analyzing the factors that influence compliance in reporting patient safety incidents is based on the theory of planned behavior, which suggests that low workplace bullying, a good patient safety culture, and high protection motivation are the primary determinants of compliance in reporting patient safety incidents.

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INTRODUCTION

Patient safety remains a cornerstone of high-quality healthcare delivery, yet preventable medical errors continue to contribute significantly to global morbidity and mortality (Falade et al., 2024). Unsafe care is estimated to result in harm to 1 in every 10 patient admissions, with a substantial proportion attributable to systemic failures and human factors (Bates et al., 2023). In response, healthcare systems worldwide have prioritized the development of robust patient safety infrastructures aimed at identifying, analyzing, and mitigating risks before they lead to adverse outcomes. Central to this effort is the systematic reporting of Patient Safety Incidents (PSIs), which are events that could have or did result in harm, serving as the primary data source for learning and improvement (Sarkar, 2025).

Despite widespread recognition of the value of incident reporting, compliance among frontline healthcare staff remains persistently low. Numerous studies have documented underreporting as a pervasive challenge, with estimates suggesting that only 10–20% of actual incidents are formally reported (Goekcimen et al., 2023). This gap is not merely a logistical issue but a cultural one, rooted in fear of blame, lack of feedback, perceived futility, and insufficient organizational support (Indriani et al., 2022). The Healthcare Safety Investigation Branch (HSIB) has explicitly highlighted that staff

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who report incidents often feel unsupported afterward, leading to disillusionment and disengagement from safety reporting systems. Without accurate and comprehensive data, organizations are left blind to latent risks, undermining efforts to foster a truly learning culture (Shojania, 2021).

The underreporting of PSIs cannot be attributed solely to individual negligence or apathy (Mash et al., 2025). Increasing evidence suggests that the organizational context, work environment design, and sociopsychological factors have a profound influence on staff behavior. Traditional approaches that focus on punitive accountability or training alone have proven insufficient (Bierbaum et al., 2025). A more nuanced understanding is required, one that acknowledges how human behavior is influenced by beliefs, social norms, and perceived control over one's actions. This calls for the application of behavioral theories that can explain, predict, and ultimately influence reporting intentions and behaviors at the individual level (Alfayez et al., 2025).

The Theory of Planned Behavior (TPB) offers a robust and empirically validated framework for understanding intentional human behavior (Lee & Vincent, 2021). TPB posits that behavioral intention—the most immediate predictor of actual behavior—is determined by three interrelated constructs: (1) behavioral beliefs, or perceptions about the outcomes of reporting and their evaluation; (2) normative beliefs, or perceptions of social pressure from peers, supervisors, or the organization to report; and (3) control beliefs, or perceptions of facilitators and barriers (e.g., time, system usability, fear of reprisal) that influence the ease or difficulty of reporting. These constructs provide a comprehensive lens through which to examine why healthcare workers choose to report—or fail to report—PSIs (Bauer et al., 2024).

While TPB has been successfully applied across diverse health domains, including vaccination uptake, hand hygiene adherence, and medication safety, it remains underutilized in the context of PSI reporting in hospital settings (Barekati et al., 2025). Existing literature often focuses on structural or technological barriers, such as cumbersome reporting systems or inadequate staffing, while neglecting the cognitive and social drivers that underpin compliance (Asante & Novak, 2024). By applying TPB, researchers can move beyond describing what barriers exist to understanding why staff perceive them as insurmountable or irrelevant, thereby enabling the design of targeted, behaviorally informed interventions (Hemsworth et al., 2024).

Understanding the factors that influence PSI reporting compliance through the TPB framework is critical for cultivating a sustainable safety culture. Policies or posters do not merely define a safety culture—it is reflected in the everyday behaviors and shared beliefs of staff (Albaalharith & A'aqoulah, 2023). When reporting is perceived as beneficial, socially endorsed, and feasible, it becomes embedded in routine practice (Gong, 2022). Conversely, when staff believe reporting is futile, stigmatizing, or beyond their control, compliance plummets regardless of system improvements. Therefore, identifying and measuring the specific behavioral, normative, and control beliefs that shape reporting intentions is a necessary precursor to designing effective interventions (Braaten & Wild, 2024).

This study aims to address a critical gap by investigating the determinants of compliance with patient safety incident reporting among healthcare professionals, grounded in the Theory of Planned Behavior. Using a structured survey instrument informed by TPB constructs, we aim to identify which beliefs most strongly predict reporting intention across different roles and departments. The findings will provide actionable insights for healthcare leaders and safety officers seeking to design context-sensitive, psychologically grounded strategies that enhance reporting rates, foster a non-punitive safety culture, and ultimately reduce preventable harm. By centering human behavior in patient safety discourse, this research makes both theoretical and practical contributions to the global agenda of safer healthcare delivery (Gorry et al., 2023).

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METHOD

This study aims to analyze the determinants influencing compliance with patient safety incident (PSI) reporting among healthcare professionals based on the Theory of Planned Behavior (TPB). Guided by this theoretical framework, the research focuses on identifying how individual and organizational factors shape behavioral intentions and actual reporting practices. Specifically, the study examines the roles of workplace bullying, patient safety culture, and protection motivation as key predictors that influence healthcare workers' decisions to report incidents of patient safety concerns. By applying a behavioral theory lens, the study seeks to uncover not only systemic barriers but also cognitive and social influences that affect reporting compliance in clinical settings.

A cross-sectional research design was employed to collect data at a single point in time from medical and nursing staff working in hospital environments. The study population consisted of 116 participants selected through simple random sampling, ensuring equal probability of selection and enhancing the representativeness of the sample. This sampling technique minimized selection bias and allowed for generalization of findings within the studied context. Participation was voluntary, and all respondents provided informed consent prior to completing the survey instruments.

The independent variables in this study were workplace bullying (X_1), patient safety culture (X_2), and protection motivation (X_3), while the dependent variable was compliance in reporting patient safety incidents (Y). Workplace bullying was assessed using the validated Workplace Bullying (WPB) Questionnaire, which measures the frequency and impact of abusive behaviors in the work environment. Patient safety culture was evaluated using the Hospital Survey on Patient Safety Culture (HSOPSC 2.0), a widely used tool that captures staff perceptions across multiple dimensions of safety climate. Protection, motivation, and attitudes toward safety reporting were assessed using the Nurses' Attitudes and Skills Safety Scale (NASUS), which was adapted for use with both nurses and medical staff.

Data collection was conducted using structured, self-administered questionnaires that had undergone validity and reliability testing to ensure the accuracy of measurement. All instruments demonstrated acceptable internal consistency, as indicated by Cronbach's alpha values of 0.70 or higher. Ethical approval for the study was obtained from the Research Ethics Committee of STRADA Indonesia University, ensuring adherence to ethical principles regarding confidentiality, voluntary participation, and the right to withdraw at any time without consequence. Participants were assured anonymity, and their responses were securely stored and accessible only to the research team.

Statistical analysis was performed using binary logistic regression to determine the strength and significance of associations between the independent variables and compliance in PSI reporting. This method was chosen because the outcome variable—reporting compliance—was dichotomous (compliant vs. non-compliant). Logistic regression enabled the estimation of odds ratios, indicating how changes in workplace bullying, safety culture, and protection motivation affected the likelihood of compliant reporting behavior. The results offer valuable insights into modifiable factors that can be targeted in interventions designed to strengthen incident reporting systems and promote a proactive patient safety culture within healthcare institutions.

RESULT

Table 1. Socio-demographic characteristics of healthcare professionals (n = 116)

Variables	Category	Frequency (n)	Percentage (%)
Sex	Female	62	53.4
	Male	54	46.6
Educational status	Diploma	37	31.9
	Degree	9	7.8
	Professions	70	60.3
Work Experience	<1 year	12	10.3
	1-5 years	85	73.3
	>5 years	19	16.4
Experience in current	No	101	87.1
	Yes	15	12.9
Job's status	Temporary workers	75	64.7
	Jobholder	41	35.3
Training	No	84	72.4
	Yes	32	27.6
Workplace bullying	High	66	56.9
	Low	50	43.1
Patient safety culture	Good	87	75.0
	Poor	29	25.0
Protection motivation	Low	62	53.4
	High	54	46.6
Compliance Patient safety incident reporting	No-Compliance	64	55.2
	Compliance	52	44.8

Based on the results of the univariate analysis, characteristics of health professionals (Table 1) are predominantly female (53.4%), are professionals with final professional education (60.3%), have worked for 1-5 years (73.3%), have never had previous work experience (87.1%), have a non-permanent employee status (64.7%), and have never been trained in quality and patient safety and safety culture (72.4%). The results also showed that most health professionals reported workplace bullying in the high category (56.9%), patient safety culture in the poor category (75.0%), protection motivation in the low category (53.4%), and compliance with reporting patient safety incidents at a non-compliant level (55.2%).

Table 2. Bivariate Analysis of Factors Influencing Compliance in Reporting Patient Safety Incidents (n = 116)

Variabel	Compliance Patient safety incident reporting		p-value
	No-Compliance (n = 64)	Compliance (n = 52)	
Sex			0.024[2)]
Female	40 (64.5)	22 (35.5)	
Male	24 (44.4)	30 (55.6)	
Educational status			0.808[1)]
Diploma	22 (59.5)	15 (40.5)	
Degree	5 (55.56)	4 (44.4)	
Professions	37 (52.9)	33 (47.1)	
Work Experience			0.182[1)]
<1 year	7 (58.3)	5 (41.7)	
1-5 years	43 (50.6)	42 (49.4)	
>5 years	14 (73.7)	5 (26.3)	
Experience in current			0.162[1)]
No	58 (57.4)	43 (42.6)	
Yes	6 (40.0)	9 (60.0)	

Variabel	Compliance Patient safety incident reporting		p-value
	No-Compliance (n = 64)	Compliance (n = 52)	
Job's status			0.087[1)]
Temporary workers	37 (49.3)	38 (50.7)	
Jobholder	27 (65.9)	14 (34.1)	
Training			0.000[2)]
No	55 (65.5)	29 (34.5)	
Yes	9 (28.1)	23 (71.9)	
Workplace bullying			0.001[1)]
High	45 (68.2)	21 (31.8)	
Low	18 (38.0)	31 (62.0)	
Patient safety culture			
Good	56 (64.4)	31 (35.6)	0.001[1)]
Poor	8 (27.6)	21 (72.4)	
Protection motivation			0.015[2)]
Low	50 (62.5)	30 (37.5)	
High	14 (38.9)	22 (61.1)	

1) chi-square (significance <0.05)
2) Fisher's Exact Test (significance <0.05)

Based on the bivariate analysis (Table 2), independent factors related to compliance in reporting patient safety incidents are gender (p-value: 0.024), history of having attended quality and patient safety training (p-value: 0.000), bullying/workplace bullying (p-value: 0.001), patient safety culture (p-value: 0.001), protection motivation (p-value: 0.015).

Table 3. Multivariate Logistic Regression Analysis of Factors Affecting Compliance in Reporting Patient Safety Incidents (n = 116)

Variabel	Compliance Patient safety incident reporting		COR (95%CI)	AOR (95%CI)	p-value)
	No (n = 64)	Compliance (n = 52)			
Sex					0.048
Female	40 (64.5)	22 (35.5)	1	1	
Male	24 (44.4)	30 (55.6)	2.27 (1.07-4.79)	2.21 (1.00-4.91)	
Training					0.001
No	55 (65.5)	29 (34.5)	1	1	
Yes	9 (28.1)	23 (71.9)	4.84 (1.98-11.82)	4.77 (1.92-11.85)	
Bullying					0.023
High	45 (68.2)	21 (31.8)	1	1	
Low	19 (38.0)	31 (62.0)	3.49 (1.61-7.55)	1.94 (0.53-7.12)	
PSI culture					0.005
Good	56 (64.4)	31 (35.6)	1	1	
Poor	8 (27.6)	21 (72.4)	4.74 (1.88-11.95)	2.92 (0.94-9.09)	
Motivation					0.010
Low	50 (62.5)	30 (37.5)	1	1	
High	14 (38.9)	22 (61.1)	2.61 (1.16-5.87)	1.05 (0.30-3.67)	

Based on multivariate analysis using logistic regression (Table 3) compliant in reporting patient safety incidents compared to men (aOR: 2.2; 95%CI: 1.00-4.91), health professionals who have attended quality and patient safety training are four times more likely to be compliant in reporting patient safety incidents compared to professionals who have never attended quality and patient safety training (aOR: 4.7; 95%CI: 1.92-11.85), low workplace bullying is twice as likely to be compliant in reporting patient safety incidents compared to high workplace bullying (aOR: 1.8; 95%CI: 0.69-4.81), good patient safety culture is three times more likely to be compliant in reporting

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patient safety incidents compared to poor patient safety culture (aOR: 2.9; 95%CI: 093-9.25), and high protection motivation is twice as likely to be compliant in reporting patient safety incidents compared to low protection motivation (aOR: 1.91; 95%CI: 0.86-4.25).

DISCUSSION

This study revealed evidence that most health professionals reported low compliance (non-compliance) in reporting patient safety incidents. The results showed that the dominant factors influencing the reporting of patient safety incidents included low workplace bullying, a good patient safety culture, high protection motivation, being more likely to be compliant in reporting patient safety incidents, being male, and being health professionals who had attended quality and patient safety training. This provides empirical evidence that bullying factors, patient safety culture, and prevention motivation can simultaneously influence compliance in reporting patient safety incidents.

From a patient safety perspective, these incidents can serve as valuable learning opportunities, considering that more than half of them are preventable. Reporting patient safety incidents is an important step in clinical risk management. After reporting, expert analysis, providing appropriate feedback, and taking corrective action to prevent the recurrence of safety incidents are essential for promoting learning and improving safety in healthcare organizations (Fekadu et al., 2025).

Consistent with previous studies that report on patient safety incidents, such as those in Addis Ababa General Hospital, Amhara Regional Referral Hospital, Gondar Comprehensive Specialized Hospital, Ghana, Ugandan health center (Kumbi et al., 2020), and Israel (Poku et al., 2023). Trained health professionals are more likely to report patient safety incidents compared to those who have not received training. Trained health professionals will be open-minded, consider the benefits of reporting errors, continue self-training, engage in training others, and accept incident reporting as the norm. A positive reporting environment will be fostered if education and training have equipped staff with an understanding of how systems fail, how harm occurs in healthcare, and how the impact of both can be mitigated (Shemsu et al., 2024).

This similarity may be because trained health professionals are more likely to be open-minded, consider the benefits of error reporting, continue their own self-training, engage in training others, and accept incident reporting as the norm. A positive reporting environment will be fostered if education and training have equipped staff with an understanding of how systems fail, how harm occurs in healthcare, and how the impact of both can be mitigated. This study is consistent with previous studies that theoretical models of organizational culture in health care have stated that leadership values and strategies, along with characteristics of organizational structure and culture, greatly influence the intermediate process domains of staffing, training, and employee safety through protection from workplace hazards (Hesgrove et al., 2024).

This study assessed the relationship between dimensions of patient safety culture and patient safety event reporting. Feedback about errors, organizational learning, and management support for safety were the most predictive dimensions of patient safety culture for the outcome assessing the frequency of patient safety event reporting. Incident reporting in healthcare refers to the collection of data on healthcare incidents to improve patient safety and quality of care (Shemsu et al., 2024). It is argued that when done well, it identifies safety hazards and guides the development of interventions to reduce risks, thereby reducing harm. These findings suggest that healthcare professionals frequently refrain from reporting patient safety incidents due to concerns about adverse reactions from administrators and colleagues. This finding represents a significant barrier to incident reporting in a patient safety culture that prevails in the hospital setting.

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Similarly, previous reviews have shown that fear of retaliation is a common barrier to incident reporting. These fears are exacerbated by organizational cultures that prioritize blame and shame. Ideally, efforts to improve patient safety culture should focus on addressing the systemic causes of incidents and utilizing these incidents as learning opportunities to enhance patient safety. Furthermore, fostering a culture of equity, where there is shared accountability across healthcare organizations, and responding to individual staff fairly and honestly (Van Marum et al., 2022).

Incident reporting is widely recognized to improve patient safety. Healthcare facilities are at high risk for morbidity and mortality; thus, this industry is considered a highly hazardous industry and requires a safety culture assessment. Consistently, these findings support previous evidence that patient safety is critical to the quality of healthcare services and remains a development challenge in many countries. Furthermore, interventions addressing patient safety culture in primary care are limited compared to those in secondary care. To improve patient safety, a crucial first step is to assess and understand an organization's safety culture. Similarly, a safety culture assessment helps healthcare organizations to assess areas for improvement and analyze changes over time (Azyabi et al., 2020).

These findings suggest that hospital administration and other relevant units should collaborate to enhance healthcare provider incident reporting, thereby improving patient safety practices. On-the-job training related to patient safety incidents should be organized and provided to healthcare providers in a timely manner. A work culture that prioritizes patient safety throughout the hospital should be encouraged to enhance patient safety incident reporting behavior. An established incident reporting system for patient safety should involve open discussion about the goals and objectives of patient safety incident reporting among hospital management and healthcare professionals. Future research should focus on the feasibility and appropriateness of a patient safety incident reporting system in hospitals to help staff utilize the reporting system effectively, as well as efforts to encourage the eradication of workplace bullying.

The findings of this study offer valuable insights for hospital leaders as they strive to enhance the rate of voluntary incident reporting. To increase the frequency of voluntarily reported patient safety incidents, this study suggests prioritizing efforts to improve incident reporting feedback mechanisms, communication about system and process changes made in response to incident reports submitted, and voicing support for safety by upper-level hospital leadership. By focusing primarily on these areas, improved incident reporting can be realized more efficiently than by attempting other forms of culture change, which can take years to implement successfully.

CONCLUSION

Health professionals who experienced low levels of workplace bullying were significantly more likely to report patient safety incidents (PSIs). Similarly, those working in environments with a strong patient safety culture and those exhibiting high levels of protection motivation demonstrated significantly higher reporting compliance. Furthermore, the combined effect of low workplace bullying, positive safety culture, and high protection motivation was associated with increased reporting compliance—particularly among male healthcare workers and those who had previously participated in quality and patient safety training, suggesting these factors may act as important mediators. These findings highlight the substantial influence of organizational climate and individual psychological factors on reporting behavior. To foster a sustainable culture of safety, healthcare managers must lead evidence-based initiatives that are context-sensitive and resource-aware, prioritizing the creation of non-punitive, supportive environments that empower staff to report incidents without fear of retribution. Targeted interventions—including ongoing safety training, anti-

bullying policies, and leadership modeling of safety values—are crucial for translating these insights into improved patient safety outcomes.

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