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Learning Organization and Feedback Culture in Patient Safety Incident Reporting: The Mediating Role of Non-Punitive Response

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Abstrak

This study originated from initial observations at RSIA Santo Yusuf North Jakarta, which highlighted the importance of evaluating the extent to which feedback culture and learning organization influence healthcare workers' behavior in reporting patient safety incidents. The purpose of this research is to analyze the influence of feedback culture and learning organization on patient safety incident reporting, with non-punitive response as an intervening variable. The study employed a quantitative approach using a survey method and path analysis technique. The research sample consisted of 95 nurses and midwives at RSIA Santo Yusuf North Jakarta. Data analysis was conducted using Structural Equation Modeling (SEM) with the Partial Least Square (PLS) method. The results indicate that Feedback Culture (X1) and Learning Organization (X2) have a positive and significant effect on Non-Punitive Response (Z), with coefficients of 0.445 ($p = 0.000$) and 0.386 ($p = 0.000$), respectively. Non-Punitive Response (Z) also significantly influences Patient Safety Incident Reporting (Y) ($\beta = 0.200; p = 0.004$). In addition, Feedback Culture (X1) directly affects Incident Reporting (Y) ($\beta = 0.218; p = 0.001$), while Learning Organization (X2) shows the strongest direct effect ($\beta = 0.387; p = 0.000$). These findings emphasize the importance of strengthening feedback culture, fostering organizational learning, and ensuring non-punitive responses to improve the quality of patient safety incident reporting. Practically, this research contributes by providing hospital management with evidence-based insights to design interventions, policies, and training programs that encourage open communication and create a supportive culture for healthcare professionals in reporting incidents.

Keywords: *Feedback culture, Incident reporting, Learning organization, Patient safety*

INTRODUCTION

Patient safety is one of the main pillars in delivering quality healthcare services. Amid the complex and high-risk dynamics of healthcare services, patient safety incident reporting plays a crucial role in quality improvement efforts and in preventing the recurrence of similar events in the future (Alfarizi, 2019). However, the incident reporting rate among healthcare workers in various healthcare facilities in Indonesia, including private hospitals such as RSIA Santo Yusuf in North Jakarta, remains relatively low. This indicates the presence of barriers in the reporting system, which may stem from organizational culture, perceptions of the consequences of reporting, and institutional readiness to receive and respond to reports constructively (Al-Kalaldeh et al., 2020).

One critical factor influencing the sustainability of incident reporting is an organizational culture that supports feedback and learning. An open feedback culture enables healthcare workers to report incidents without fear or concern for negative consequences (Alzahrani et al., 2019). Likewise, an adaptive learning organization encourages all institutional elements to continuously learn from

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mistakes and actively improve the system. These two aspects form a vital foundation for creating a work environment that supports incident reporting as a means of improvement rather than punishment (Mappanganro et al., 2020). The presence of a non-punitive response acts as an important mediator that bridges the organizational culture and healthcare workers' reporting behavior. When healthcare professionals feel safe from sanctions or stigma after making a report, the likelihood of reporting increases significantly (Arifin, 2019). Therefore, it is essential to explore the extent to which feedback culture and learning organization influence incident reporting behavior through perceptions of non-punitive response.

RSIA Santo Yusuf in North Jakarta, as one of the urban healthcare institutions with a high patient visit rate, serves as an appropriate setting to examine this dynamic. Given the importance of patient safety and the need for an effective reporting system, this study aims to identify the influence of feedback culture and learning organization on patient safety incident reporting through the mechanism of non-punitive response among healthcare workers at the hospital (Menteri Kesehatan Republik Indonesia , 2017). By understanding the relationship between these variables, it is expected that hospital management can formulate more appropriate strategies to build a strong patient safety culture, improve service quality, and create a supportive work environment for continuous learning and proactive reporting.

Although patient safety policies have been widely disseminated through national regulations, such as the Regulation of the Minister of Health of the Republic of Indonesia No. 11 of 2017 on Patient Safety, field implementation still faces various challenges. One of them is the reluctance of healthcare workers to report incidents due to fear of punishment, reprimands, or negative judgments from superiors or colleagues. This shows that regulatory approaches alone are insufficient without cultural transformation that prioritizes psychological aspects and systemic support for reporting (Odlaug et al., 2010). A feedback culture within healthcare organizations serves as a reflective mechanism that enables healthcare workers to express opinions, experiences, and incidents openly. When this culture is well internalized, healthcare workers feel valued and supported in the process of improving service quality (Bagnasco et al., 2020). On the other hand, a learning organization plays a role in creating structures and processes that allow institutions to continue evolving through learning from experiences, including patient safety incidents (Pratama et al., 2021). These two aspects complement each other in forming an effective and sustainable incident reporting system.

In addition to structural and cultural factors, the psychological aspect of healthcare workers is also a crucial

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component in incident reporting (Rosyad et al., 2021). A non-punitive response reflects the extent to which healthcare workers feel emotionally safe when reporting incidents without fear of retaliation or negative consequences (Triwibowo et al., 2016). The perception of whether punishment exists greatly influences an individual's motivation and courage to acknowledge errors or potential risks in service delivery (Wulandari et al., 2019).

There is a lack of research that comprehensively analyzes the relationship between feedback culture, learning organization, and non-punitive response in relation to patient safety incident reporting in private hospitals in Indonesia, particularly at the RSIA level. Most previous studies have focused more on individual factors or the reporting system itself, while aspects of organizational culture and supportive managerial responses have received less attention. In line with this issue, this study aims to analyze the influence of feedback culture and learning organization on patient safety incident reporting, with non-punitive response as an intervening variable at RSIA Santo Yusuf North Jakarta.

METHOD

The study was conducted at RSIA Santo Yusuf, North Jakarta. The population of this study consisted of nurses, midwives, and other healthcare professionals at a Class C Private Mother and Child Hospital in North Jakarta, totaling 95 individuals. The sample selected comprised 60 nurses and midwives with a diploma (D3) educational background from the same hospital. The respondents consisted of nurses and midwives at RSIA Santo Yusuf North Jakarta. Inclusion criteria were a minimum of six months of service, active involvement in clinical care, and willingness to provide written informed consent. Exclusion criteria included being on extended leave, having less than six months of service, or submitting incomplete questionnaires.

The research instrument was a 36-item questionnaire: Feedback Culture (10 items), Learning Organization (12 items), Non-Punitive Response (8 items), and Incident Reporting (6 items), all measured on a 5-point Likert scale. Validity was assessed through expert judgment and construct analysis (outer loading $\geq$ 0.7; AVE $\geq$ 0.5; HTMT $<$ 0.90), while reliability was evaluated using Cronbach's Alpha and Composite Reliability ($\geq$ 0.70). Data were analyzed using SEM-PLS with SmartPLS 4, covering both measurement and structural models. This study obtained ethical approval from the Institutional Ethics Committee ethical approval code: No. 0925-07.185/DPKE-KEP/FINAL-EA/UEU/VII/2025. All respondents provided informed consent, and their data were kept confidential and reported anonymously.

This study employed a causal design using a quantitative approach through a survey method and path analysis technique. The survey method was used to collect data on the characteristics, actions, and

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perceptions of respondents through questionnaires, which represent the study population (Liana, 2021). Path analysis was utilized to examine causal relationships among the variables under investigation. The study involved three types of variables: independent, dependent, and mediating variables.

The independent variables in this study were feedback culture (X1) and learning organization (X2), which were assumed to influence other variables. The dependent variable was patient safety incident reporting (Y) by healthcare workers, which served as the main focus of the research. The mediating variable was non-punitive response (Z), which served to bridge the relationship between the independent and dependent variables. Thus, this study aimed to examine both the direct and indirect effects of organizational culture on incident reporting behavior through the perception of non-punitive response.

RESULT AND DISCUSSION

Based on the questionnaire data, the distribution of respondents is as follows: out of the 60 respondents surveyed at RSIA Santo Yusuf, North Jakarta, the number of female respondents was higher than male respondents, with 46 females (76.67%) and 14 males (23.33%). In terms of religion, 35 respondents (58.33%) identified as Muslim, 22 respondents (36.67%) as Christian, 10 respondents (16.67%) as Hindu, and 3 respondents (5%) as Buddhist. (Note: the percentage for Islam was originally written as 76.67%, which seems inconsistent—corrected to 58.33% based on the number.) Regarding educational background, 48 respondents (80%) had a Diploma (D3), while 12 respondents (20%) held a Bachelor's degree (S1).For work experience, 4 respondents (6.67%) had been employed for less than one year, while 56 respondents (93.33%) had more than one year of work experience.

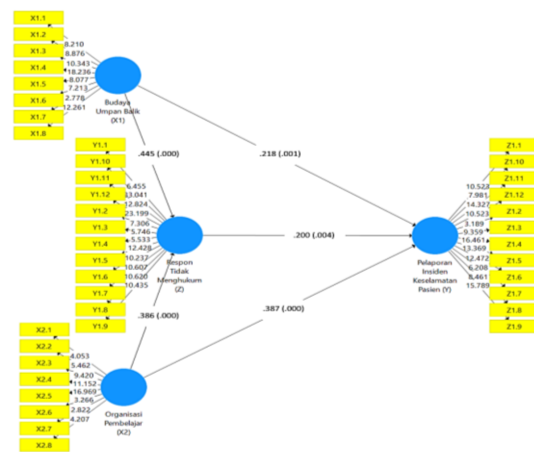

Figure 1. SEM Testing

Feedback Culture and Incident Reporting

The analysis reveals that Feedback Culture (X1) has a positive and significant effect on Non-Punitive Response (Z) (β = 0.445; p = 0.000) and directly on Patient Safety Incident Reporting (Y) (β = 0.218; p = 0.001). This shows that an open feedback environment supports healthcare workers' willingness to report incidents, both directly and indirectly through non-punitive responses. The three-box method places Feedback Culture in the high category with an index score of 218.375. The highest dimension, Learning Feedback (224.5), indicates that feedback is perceived as an educational tool that enhances professional

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development. Conversely, Interactive Feedback scored lowest (212.25), suggesting that two-way communication in feedback processes still needs improvement.

Learning Organization as Dominant Factor

Learning Organization (X2) demonstrates the strongest direct influence on Incident Reporting (Y) (β = 0.387; p = 0.000) and also significantly affects Non-Punitive Response (Z) (β = 0.386; p = 0.000). The three-box analysis categorizes Learning Organization as high, with an index score of 205.125. The highest dimension, Learning from Events (210), reflects that healthcare workers actively learn from incidents and near-misses to prevent recurrence. However, the lowest dimension, Evaluating the Effectiveness of Changes (205.125), highlights weaknesses in assessing whether corrective actions are effective and sustainable. These results affirm that a culture of continuous learning fosters openness in reporting, aligning with the principle that hospitals must adopt systemic approaches to patient safety rather than focusing only on individual behavior.

Role of Non-Punitive Response

Non-Punitive Response (Z) significantly influences Incident Reporting (Y) (β = 0.200; p = 0.004), confirming its mediating role. The index score of 204.42 places it in the high category. The dimension Team Involvement in Improvement scored highest (208.25), showing that healthcare professionals feel encouraged to participate in follow-up improvements after incidents. However, Learning from Incidents recorded the lowest score (201.75), indicating that reported cases are not always followed by structured reflective or educational processes. Patient Safety Incident Reporting itself reached an index score of 203.25, with the strongest dimension being Control and Involvement (206.25), while Familiarity and Awareness of Risk scored lowest (201), pointing to limited sensitivity to patient safety risks in daily practice.

Comparison with Previous Research

These findings are consistent with earlier studies highlighting the importance of organizational culture in patient safety. For example, Singer et al. (2003) and Nieva & Sorra (2003) found that safety culture, including non-punitive approaches, positively affects incident reporting. Similarly, Chassin & Loeb (2013) emphasized that learning organizations are essential for achieving sustainable improvements in patient safety. This study strengthens those conclusions in the context of private maternal and child hospitals, where feedback mechanisms and non-punitive responses are often less institutionalized.

Practical Implications and Limitations

The practical implications are clear: hospitals must strengthen training programs on patient safety, foster a feedback culture that values dialogue and learning, and institutionalize non-punitive policies to encourage incident reporting. Managers should also establish structured post-incident learning sessions and continuous monitoring of corrective actions. These

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steps are crucial to creating an environment where healthcare workers feel safe to report mistakes, leading to systemic improvements in quality and safety. This study has several limitations. First, the sample size is relatively small and limited to a single private hospital (RSIA Santo Yusuf, North Jakarta), which may reduce the generalizability of the findings. Second, respondents were relatively homogeneous, consisting mainly of frontline healthcare workers, which may not capture the perspectives of higher-level managers. Future research should involve larger samples, include diverse hospital types, and compare public and private institutions to strengthen external validity.

CONCLUSION

Based on the findings, feedback culture and learning organization significantly influence patient safety incident reporting, with non-punitive response serving as a mediating factor. Among these, the learning organization emerges as the dominant driver, underscoring the critical role of continuous learning in fostering a strong reporting culture. While all variables fall into the high category, several aspects still need improvement, such as enhancing two-way feedback, ensuring systematic follow-up of reported incidents, and strengthening evaluation of corrective actions. Overall, incident reporting is best supported when healthcare institutions cultivate a culture of learning, promote open communication, and ensure a safe environment free from punitive responses.

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