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The Implementation of Patient Safety Goals on the Prevalence of Patient Safety Incidents

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ABSTRACT

Patient safety is a top priority in healthcare services, yet the rate of Patient Safety Incidents (PSI) remains a significant challenge in primary health care facilities. In Bojonegoro Regency, the implementation of the six Patient Safety Goals (PSG) in health clinics serves as a crucial indicator in determining the quality of care and patient safety. This study aims to analyze the relationship between the implementation of Patient Safety Goals (PSG) and the prevalence of Patient Safety Incidents (PSI) in health clinics within the Bojonegoro Regency area. This research is a quantitative analytical study with a cross-sectional design. The research population includes all clinics in Bojonegoro Regency, with 28 clinics selected using a purposive sampling technique. Data were collected through structured questionnaires regarding PSG compliance and observation of annual incident report documents. Data analysis was performed using the Chi-square statistical test. The results showed that the level of PSG implementation in the 28 health clinics fell into the 'good' category at 78.5%. Meanwhile, the prevalence of PSI was 14.25%. Analysis based on the Chi-square test indicated a significant relationship between PSG implementation and PSI prevalence, with a p-value = [0.043 < 0.05]. The higher the level of compliance with patient safety goals, the lower the prevalence of incidents harmful to patients. The implementation of Patient Safety Goals has a strong correlation with the prevalence of PSI in Bojonegoro health clinics. It is recommended for clinic managers to strengthen a no-blaming culture incident reporting system and increase routine supervision of the six patient safety goals.

Keywords: Patient Safety, Patient Safety Goals (PSG), Patient Safety Incidents (PSI), Health Clinic

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INTRODUCTION

Quality healthcare services are not only measured by technological sophistication or the completeness of facilities but by the extent to which patient safety is maintained during the care process. In contemporary healthcare systems, patient safety has become a central indicator of service quality and organizational reliability. Globally, patient safety is recognized as a core dimension of healthcare quality, alongside effectiveness, efficiency, equity, timeliness, and patient-centeredness. The World Health Organization has consistently emphasized that preventable harm remains one of the leading causes of morbidity and mortality in healthcare settings, particularly in low- and middle-income countries where system variability and reporting limitations persist. Therefore, the integration of safety principles into routine healthcare delivery is no longer optional but an ethical and professional imperative.

At the primary healthcare level, such as clinics, patient safety management serves as the fundamental foundation in daily operations to ensure services are free from avoidable harm (Setyawulandari, 2025). Clinics function as the frontline of healthcare delivery, where most patients first interact with the health system; therefore, the implementation of safety standards at this level has a direct impact on overall public health outcomes. Unlike tertiary hospitals that may have advanced safety infrastructure and specialist supervision, primary clinics often operate with limited resources and high patient flow, making structured safety systems even more crucial. In this context, patient safety is

closely intertwined with the quality of clinical governance, staff competence, leadership commitment, and organizational culture.

The implementation of Patient Safety Goals (PSG) is not merely a fulfillment of accreditation standards but a systematic instrument to prevent preventable medical errors. The six Patient Safety Goals—covering accurate patient identification, effective communication, safe medication practices, infection prevention, surgical safety, and fall risk reduction—are designed to minimize both active errors and latent system failures. These goals represent operational translations of patient safety theory into daily clinical routines. Each goal addresses a high-risk domain frequently associated with adverse events in healthcare facilities worldwide. However, reality in the field shows that the consistency of PSG implementation often varies across institutions, especially in health clinics at the regency level that have diverse resources and workloads (Nugrahaeni & Yuliani, 2021). Variability in staffing levels, infrastructure, leadership commitment, and monitoring systems may influence the degree to which safety protocols are implemented effectively. In rural or semi-urban regions, clinics may face constraints such as limited training opportunities, documentation overload, and insufficient supervision mechanisms. This variability creates uneven safety performance across facilities operating under the same regulatory framework.

This is reinforced by the fact that poorly internalized safety standards risk creating gaps for incidents that directly harm patients. When safety practices are treated merely as administrative requirements rather than embedded professional values, the risk of adverse events increases substantially. Compliance driven by external inspection tends to be temporary, whereas compliance rooted in intrinsic professional awareness tends to be sustainable. Therefore, the challenge lies not only in enforcing standards but in cultivating a safety-oriented mindset among healthcare providers. The urgency of this research lies in the need for a comprehensive mapping of the extent to which patient safety standards have been internalized in clinical practice in Bojonegoro Regency. With 36 health clinics actively operating, there is a risk of heterogeneity in the understanding and compliance with the six patient safety goals. Such heterogeneity may create disparities in service quality and patient protection across facilities. From a systems perspective, inconsistent implementation weakens the overall reliability of the regional healthcare network.

Without a valid evaluation of PSG implementation, the rate of Patient Safety Incidents (PSI) potentially remains high or even unreported (under-reporting). Under-reporting is a well-documented phenomenon in patient safety research, often linked to fear of blame, lack of reporting systems, and limited awareness of incident classification. In many primary care settings, incident reporting is perceived as punitive rather than corrective, leading to concealment rather than transparency. Consequently, official data may underestimate the true prevalence of adverse events. Recent studies show a strong correlation between safety management structures and the frequency of incident occurrences (Rumah et al., 2024). Furthermore, the compliance of healthcare workers in performing patient identification and effective communication is a major determinant in reducing medical errors in healthcare facilities (Fitrianarti, 2021). Effective communication, particularly during patient handovers and medication administration, has been consistently identified as a critical factor in preventing adverse events. Misidentification and communication breakdown remain among the most frequently reported causes of preventable harm globally.

On the other hand, the role of leadership in overseeing PSG implementation at the clinic level is often a weak point, resulting in high rates of incidents that are actually preventable (Panggalih dkk., 2023). Leadership commitment is essential in shaping organizational culture, allocating resources, and ensuring continuous monitoring of safety indicators. Without proactive leadership engagement, PSG implementation may deteriorate into a checklist exercise rather than a dynamic safety process. Therefore, conducting a study on 28 health clinics in Bojonegoro is highly urgent to see the "big picture" regarding the effectiveness of patient safety systems at the regency level. A regional-level analysis provides valuable insights into systemic strengths and weaknesses rather than isolated institutional cases. This broader approach allows policymakers to identify structural patterns rather than focusing solely on individual facility deficiencies.

This is supported by findings that weak incident reporting systems are often rooted in low staff understanding of the safety goals themselves (Arini et al., 2020). When healthcare workers lack clarity about the purpose and procedures of PSG, compliance tends to decline over time. Inadequate training, minimal supervision, and limited feedback loops further weaken adherence. Given the role of clinics as the frontline of service, solid PSG integration is an absolute prerequisite to guarantee broad public safety (Hasanah, 2024). Patient safety issues in health clinics in Bojonegoro Regency have developed alongside the transition of national accreditation policies that require strict implementation of the six Patient Safety Goals (Kemenkes, 2022). National health policy reforms have emphasized standardized quality assurance and measurable safety indicators across healthcare facilities. However, in practice, a gap has emerged between formal regulations and daily clinical practices in the field. Regulatory compliance does not always translate into behavioral compliance among healthcare providers.

Chronologically, this phenomenon began with an intensive administrative adaptation phase, followed by a decline in consistent staff compliance after the accreditation assessment ended due to the perception that PSG is merely a documentation burden. This post-accreditation decline highlights the challenge of sustaining safety culture beyond formal evaluations. Sustainability requires internal motivation, organizational reinforcement, and continuous supervision mechanisms. This condition is exacerbated by the trend of very low or zero reported Patient Safety Incidents (PSI) across various clinics, which theoretically indicates problems with under-reporting and a strong blaming culture. In safety management theory, an absence of reported incidents does not necessarily reflect the absence of errors but may signal weaknesses in surveillance and reporting systems. Consequently, risks of medical errors such as patient identification failure and verbal communication errors accumulate covertly without systematic evaluation, creating an urgency to analyze the extent to which the implementation of these goals truly correlates with the prevalence of real incidents in those 36 health clinics (Mustamin dkk., 2022; Nugrahaeni & Yuliani, 2021).

If inconsistent implementation of Patient Safety Goals and low incident reporting are allowed to continue, the most fatal impact will be an increase in Adverse Events (AE) that can cause permanent disability or even patient death in clinics. Beyond clinical consequences, the institutional impact is equally significant. Institutionally, this will erode public trust in primary healthcare facilities in Bojonegoro, which in turn reduces the number of visits and the collective reputation of the clinics. Moreover, the lack of accurate data on the prevalence of Patient Safety Incidents (PSI) results in clinic management losing the basis for quality improvement, causing the same cycle of errors to recur and potentially leading to legal claims (malpractice) for healthcare workers and clinic owners (Setyawulandari, 2025; Panggalih dkk., 2023). Thus, patient safety is not only a clinical issue but also a legal, managerial, and socio-economic concern that influences institutional sustainability.

Strategic steps to strengthen patient safety culture must become a priority through leadership that supports a no-blaming culture reporting system across all health clinics. A non-punitive reporting environment encourages transparency and continuous learning from errors. Integrating PSG monitoring into daily performance evaluations and utilizing digital technology for incident reporting can minimize administrative barriers and increase the accuracy of PSI prevalence data. Digital reporting systems can facilitate real-time data collection, trend analysis, and early detection of safety risks. The results of this study are expected to serve as a basis for formulating evidence-based intervention policies for the District Health Office and clinic managers (Arini et al., 2020; Hasanah, 2024). Evidence-based policymaking ensures that improvements in safety systems are grounded in empirical findings rather than assumptions.

The study purpose was to analyze the relationship between the implementation of Patient Safety Goals and the prevalence of Patient Safety Incidents in health clinics in Bojonegoro Regency. By examining this relationship quantitatively, the study aims to provide empirical evidence on whether stronger PSG compliance is associated with lower incident prevalence, thereby contributing to the development of safer primary healthcare services at the regional level and strengthening the sustainability of patient safety systems in primary care settings.

MATERIALS AND METHODS

The research population includes all 44 clinics in Bojonegoro Regency; however, using a purposive sampling technique, the sample was set at 28 health clinics after excluding those in the beauty category. The exclusion of beauty clinics was based on the consideration that such facilities primarily focus on aesthetic procedures and do not fully represent general clinical services that routinely implement comprehensive patient safety goals. Therefore, the final sample consisted exclusively of general health clinics that provide primary medical services and are directly involved in implementing standardized patient safety procedures.

Purposive sampling was selected to ensure that only clinics meeting specific inclusion criteria relevant to the study objectives were included. This technique allows the researcher to deliberately select units that possess characteristics essential for examining the relationship between Patient Safety Goals (PSG) implementation and Patient Safety Incidents (PSI). The inclusion criteria for this research were accredited clinics willing to provide data related to patient safety goals and incident reports. Clinics that did not have formal accreditation status or refused to provide access to safety-related data were excluded from the study.

The final sample of 28 clinics represents a substantial proportion of the total eligible clinics in the regency, thereby providing an adequate overview of patient safety practices at the primary healthcare level. The decision to focus on accredited clinics ensures that all participating facilities operate under standardized regulatory frameworks, allowing for a more controlled comparison of PSG implementation levels. Additionally, including clinics across different geographic areas within Bojonegoro Regency enhances representativeness and allows for broader interpretation of findings at the regional level.

Study Organization

This study employs a quantitative analytical design with a cross-sectional approach to analyze the relationships between variables at a single point in time. The cross-sectional design was chosen because it enables the assessment of both the independent and dependent variables simultaneously without requiring longitudinal follow-up. This design is appropriate for identifying statistical associations between the level of PSG implementation and the prevalence of PSI within the selected clinics. The sample was selected using a purposive sampling technique. The inclusion criteria for this research were accredited clinics willing to provide data related to patient safety goals and incident reports. By focusing on clinics that have undergone accreditation processes, the study ensures that the baseline safety standards are relatively comparable across institutions. This enhances internal validity by minimizing extreme variability in regulatory compliance.

The measured independent variable is the implementation level of the six patient safety goals. These six goals include accurate patient identification, effective communication, medication safety, infection prevention and control, procedural safety, and fall risk reduction. The level of implementation was assessed using a structured questionnaire designed to evaluate compliance with each component of the PSG framework. The questionnaire items were developed based on national accreditation standards and relevant patient safety guidelines. Responses were categorized into levels such as “Good” and “Good enough” to reflect the overall quality of implementation in each clinic.

The dependent variable is the prevalence of patient safety incidents, categorized into “occurrence” and “no occurrence.” Patient Safety Incidents (PSI) were defined as any unintended events or circumstances that could have or did result in harm to a patient during the provision of healthcare services. Data regarding PSI were obtained through a combination of self-reported questionnaires and direct observation of incident report documents available at each clinic. By cross-checking questionnaire responses with documented reports, the researcher aimed to increase the accuracy and credibility of the collected data.

Data were collected through questionnaires and observation of incident report documents at each clinic. The data collection process was conducted systematically, beginning with formal permission from clinic management. The researcher explained the study objectives and ensured confidentiality of institutional data. Questionnaires were distributed to responsible personnel, such as clinic managers or

designated patient safety officers. Subsequently, document reviews were conducted to verify reported incidents and assess the consistency of safety reporting practices.

To enhance data reliability, standardized data collection procedures were applied across all clinics. The same instrument and observation checklist were used for each facility to minimize measurement bias. In addition, clarification sessions were conducted when necessary to ensure that respondents fully understood each questionnaire item. This step was essential to reduce misinterpretation and improve response accuracy.

Statistical Analysis

Data analysis was conducted univariately to examine frequency distributions and bivariately using the chi-square statistical test at a significance level of 0.05 to prove the existence of a significant relationship between compliance with standard implementation and the rate of incident occurrences in the field. Univariate analysis was first performed to describe the characteristics of the clinics and to determine the distribution of variables, including the level of PSG implementation and the prevalence of PSI. Frequency and percentage distributions were calculated to provide a clear overview of how many clinics fell into each category. This descriptive analysis serves as the foundation for understanding the general pattern of patient safety practices in Bojonegoro Regency.

Bivariate analysis was conducted using the chi-square test to examine the association between the independent variable (PSG implementation level) and the dependent variable (PSI prevalence). The chi-square test is appropriate for categorical data and allows for the identification of statistically significant relationships between two nominal variables. A significance level (α) of 0.05 was established as the threshold for statistical decision-making. If the obtained p-value was less than 0.05, the relationship between PSG implementation and PSI prevalence was considered statistically significant.

The selection of the chi-square test aligns with the categorical nature of the data, as both PSG implementation and PSI prevalence were grouped into defined categories. The test evaluates whether the observed distribution of incidents across different levels of PSG compliance differs significantly from what would be expected by chance. This statistical approach strengthens the inferential validity of the study by providing objective evidence regarding the relationship between safety standard implementation and incident occurrence.

All statistical analyses were conducted using standard statistical software to ensure accuracy and reproducibility. The findings of the statistical tests were interpreted in light of both statistical significance and practical relevance, considering the implications for patient safety management at the clinic level.

RESULT AND DISCUSSION

General Data

Clinic Characteristics based on Clinic Type and Accreditation Status

Table 1 Frequency Distribution of Characteristic Data based on Clinic Type and Accreditation Status

Variable	Frequency	Percentage
Clinic Types		
Primary	5	18%
Pratama	23	82%
Accreditation Status		
Paripurna (Execelent)	27	96%
Primary	1	4%

Source: Primary Data (2025)

Table 1 presents the distribution of clinics based on type and accreditation status. The majority of clinics were classified as Pratama clinics (82%), while Primary clinics accounted for 18%. In terms of accreditation status, nearly all clinics (96%) had achieved Paripurna (Excellent) accreditation, with only 4% categorized as Primary accreditation. These findings indicate that most clinics included in this study

operate at the Pratama level and have achieved the highest accreditation standard (Paripurna). The predominance of highly accredited clinics suggests that the facilities included in this study generally meet national standards for service quality and patient safety management. Based on Table 1, the majority of clinic types are Pratama at 82%, and the accreditation status is Paripurna (Execelent) at 96%.

Specific Data

Table 2 Cross-tabulation of Patient Safety Goals (PSG) and Prevalence of Patient Safety Incidents (PSI)

	Prevalence of Patient Safety Incidents (PSI) None	Prevalence of Patient Safety Incidents (PSI) an accident	Total
Patient Safety Goals (PSG) Good	21 75%	1 3,5%	22 78,5%
Patient Safety Goals (PSG) Good enough	3 10,75%	3 10,75%	6 21,5%
Total	24 85%	4 14,25%	28 100%

Source: Primary Data (2025)

Table 2 shows the cross-tabulation between **Patient Safety Goals (PSG)** assessment and the **Prevalence of Patient Safety Incidents (PSI)**. Among clinics with a **"Good" PSG assessment**, 75% reported **no patient safety incidents**, while only 3.5% reported that incidents had occurred. In contrast, clinics categorized as having **"Good enough" PSG assessment** showed an equal proportion (10.75%) of no incidents and reported incidents. Overall, 85% of clinics reported no patient safety incidents, whereas 14.25% reported the occurrence of at least one incident. These findings suggest a trend in which better implementation of Patient Safety Goals is associated with lower incidence of patient safety events.

Based on Table 2, the assessment of "Good" PSG with "None" for PSI prevalence is 75%, and "Good" PSG with "Occurred" for PSI prevalence is 3.5%. Results of the analysis regarding the relationship between the assessment of Patient Safety Goals (PSG) and Patient Safety Incidents (PSI) using the Chi-Square test show a p-value = 0.043 ($p < 0.05$). Statistically indicates a significant relationship or influence between the assessment of Patient Safety Goals (PSG) and Patient Safety Incidents (PSI).

Discussion

The research results indicate a significant relationship between the assessment of Patient Safety Goals (PSG) and the prevalence of Patient Safety Incidents (PSI) with a p-value of 0.043. The data shows that 75% of respondents with a "Good" PSG assessment successfully achieved a zero-incident condition (PSI), while a decrease in the quality of the PSG assessment to "Fair" was directly proportional to an increase in incident occurrences by 10.75%. This proves that compliance with safety standard procedures is a primary determinant in reducing medical errors within the clinic environment.

From a statistical perspective, the p-value below the 0.05 threshold indicates that the observed association is unlikely to have occurred by chance, thereby strengthening the inference that higher PSG compliance is linked to reduced incident prevalence. Clinically, this finding suggests that structured adherence to safety protocols plays a preventive role in minimizing adverse events. The proportional increase in incidents when PSG implementation declines further supports the dose–response relationship between safety compliance and patient outcomes. Therefore, the quality of PSG implementation can be interpreted not merely as an administrative requirement but as a measurable predictor of patient safety performance.

Theoretically, the implementation of PSG is a manifestation of injury prevention efforts through a structured system. According to Galleryzki et al. (2021), the six patient safety goals—ranging from identification to fall risk—are critical instruments designed to break the chain of human error in healthcare services. The positive relationship found in this study reinforces the theory that safe nursing behavior, grounded in a good understanding of PSG, creates a strong layer of protection for patients.

In addition, safety science literature emphasizes the "Swiss Cheese Model" of error prevention, where multiple safety barriers function collectively to prevent harm. PSG can be conceptualized as one of these critical safety layers. When consistently implemented, they reduce latent system failures and active human errors. The present findings empirically support this theoretical framework by demonstrating that stronger compliance with PSG corresponds with lower PSI rates. Thus, PSG implementation not only reflects procedural adherence but also operationalizes patient safety theory into daily clinical practice.

Furthermore, research by Setyawulandari (2025) emphasizes that patient safety incidents often stem from communication failures and inaccurate identification. In the context of clinics with "Paripurna" (Excellent) accreditation status (96%), compliance with PSG is no longer just an option but a behavioral standard that must be internalized by every healthcare professional. This aligns with the Patient Safety Culture concept proposed by Rumah (2024), where healthcare organizations focused on safety will automatically have lower incident rates because every staff member feels responsible for collective safety.

The high percentage of Paripurna accreditation observed in this study indicates that most clinics have already fulfilled structural and procedural standards of quality assurance. However, accreditation alone does not guarantee safety outcomes unless it is supported by a strong organizational culture. Patient Safety Culture emphasizes shared values, open communication, non-punitive error reporting, and collective accountability. Therefore, the significant relationship found in this study may also reflect the synergistic interaction between formal accreditation systems and the internalization of safety values among healthcare workers.

The researcher believes that the effectiveness of PSG in reducing PSI is highly influenced by the factor of self-awareness, or the nurse's ability to recognize potential hazards before they occur. Although the system (such as accreditation) is already at the highest level, the human factor still plays a key role. Hasanah & Wijaya (2024) state that nurses who possess critical awareness of their duties will be more compliant with PSG protocols compared to those who work solely based on routine.

From a behavioral and cognitive perspective, self-awareness can be understood as reflective professional practice, where healthcare providers continuously evaluate risks and anticipate potential errors. Even in highly accredited systems, patient safety ultimately depends on frontline staff vigilance and ethical responsibility. Human factors engineering research consistently highlights that organizational systems and individual cognition are interdependent components of safety performance. Therefore, strengthening PSG implementation should not only focus on regulatory compliance but also on fostering critical thinking, professional accountability, and proactive risk identification among nurses and clinical staff.

CONCLUSIONS

The higher the level of compliance with patient safety goals, the lower the prevalence of incidents harmful to patients. The implementation of Patient Safety Goals has a strong correlation with the prevalence of PSI in Bojonegoro health clinics. It is recommended for clinic managers to strengthen a no-blaming culture incident reporting system and increase routine supervision of the six patient safety goals.

REFERENCES

Arini, D., Yuliastuti, C., & Ito, R. L. J. (2019). Hubungan Tingkat Pengetahuan Perawat tentang Identifikasi dalam Patient Safety dengan Pelaksanaannya di Ruang Rawat Inap RSUD SK. Lerik

Kupang. Jurnal Ilmiah Keperawatan, 14(2), 87-99. http://journal.stikeshangtuah-sby.ac.id/index.php/...

Fitrianarti, R. (2021). Analisis Faktor Penyebab Insiden Keselamatan Pasien Di Rawat Inap (Skripsi Literature Review) (Doctoral dissertation, STIKES Yayasan RS Dr. Soetomo Surabaya).

Galleryzki, A. R., Hariyati, R. T., Afriani, T., & Rahman, L. O. (2021). Hubungan sikap keselamatan dengan implementasi sasaran keselamatan pasien oleh perawat di rumah sakit. Jurnal Kepemimpinan Dan Manajemen Keperawatan, 4(1), 11-22. http://doi.org/10.32584/jkmk.v4i1.855

Hasanah, S. W. (2024). Strategi implementasi keselamatan pasien untuk meningkatkan kualitas pelayanan di rsud abdoel wahab sjahranie. Nusantara Innovation Journal, 3(1), 12-43. DOI: https://doi.org/10.70260/nij.v3i1.45

Kementerian Kesehatan Republik Indonesia. (2022). Keputusan Menteri Kesehatan Republik Indonesia Nomor HK.01.07/MENKES/1983/2022 tentang Standar Akreditasi Klinik. Jakarta: Kemenkes RI

Mustamin, A. Y., Pratama, Y. Y., Mohamad, S. W., Putri, T. E., Marwati, T. A., & Sulistyawati, S. (2022). Analisis Budaya Keselamatan Pasien Di Klinik Pratama: Literature Review. Jurnal Kesehatan Komunitas Indonesia, 18(2). DOI: https://doi.org/10.37058/jkki.v18i2.4520.

Nugraheni, S. W., Yuliani, N., & Veliana, A. D. (2021, June). Studi literatur: budaya keselamatan pasien dan insiden keselamatan pasien di rumah sakit. In Prosiding Seminar Informasi Kesehatan Nasional (pp. 290-295). *https://doi.org/10.47701/sikenas.v0i0.1264*

Panggalih, D., Susanti, S. S. A. M. E., & Yunita, A. (2023). Efektifitas Edukasi Budaya Keselamatan Terhadap Penerapan Keselamatan Pasien Effectiveness of Safety Culture Education on Patient Safety Implementation.

Rumah, A. (2024). Pengaruh penerapan standar akreditasi terhadap mutu dan keselamatan pasien. http://arl.ridwaninstitute.co.id/index.php/arl

Setyawulandari, O., Dewi, R. A. E. P., & Marchamah, D. N. S. (2025). Hubungan Penerapan Rekam Medis Elektronik Dengan Manajemen Risiko Keselamatan Pasien Di Puskesmas X Kota Malang. *Indonesian Journal of Health Community*, *6*(2), 98-107. https://doi.org/10.31331/ijheco.v6i2.3786