


Health Workers' Perspective on Patient Safety Incident Disclosure in Indonesian Hospitals: A Mixed-Methods Study

Inge Dhamanti ¹⁻³, Ni Njoman Juliasih⁴, I Nyoman Semita⁵, Nasriah Zakaria^{6,7}, How-Ran Guo⁸, Vina Sholikhah²

¹Department of Health Policy and Administration, Faculty of Public Health, Universitas Airlangga, Surabaya, Indonesia; ²Center for Patient Safety Research, Universitas Airlangga, Surabaya, Indonesia; ³School of Psychology and Public Health, La Trobe University, Melbourne, VIC, Australia; ⁴Department of Public Health, School of Medicine, Universitas Ciputra Surabaya, Surabaya, Indonesia; ⁵Department of Orthopedic, Faculty of Medicine, University of Jember, Jember, Indonesia; ⁶College of Applied Science, Al Maarefa University, Riyadh, Saudi Arabia; ⁷Ehealth Unit, Faculty of Medicine, University Malaya, Kuala Lumpur, Malaysia; ⁸Department of Environmental and Occupational Health, National Cheng Kung University, Tainan, Taiwan

Correspondence: Inge Dhamanti, Department of Health Policy and Administration, Faculty of Public Health, Universitas Airlangga, Surabaya, 60115, Indonesia, Tel +628 2336099800, Email inge-d@fkm.unair.ac.id

Purpose: This study examined how health staff in Indonesian hospitals perceived open disclosure of patient safety incidents (PSIs).

Patients and Methods: This study employed a mixed method explanatory sequential approach. We surveyed 262 health workers and interviewed 12 health workers. Descriptive statistical (frequency distributions and summary measures) analysis was performed to assess the distributions of variables using SPSS. We used thematic analysis for the qualitative data analysis.

Results: We discovered a good level of open disclosure practice, open disclosure system, attitude toward open disclosure and process, open disclosure according to the level of harm resulting from PSIs in the quantitative phase. The qualitative phase revealed that most participants were confused about the difference between incident reporting and incident disclosure. Furthermore, the quantitative and qualitative analyses revealed that major errors or adverse events should be disclosed. The contradictory findings may be due to a lack of awareness of incident disclosure. The important factors in disclosing the incident are effective communication, type of incident, and patient and family characteristics.

Conclusion: Open disclosure is novel for Indonesian health professionals. A good open disclosure system in hospitals could address several issues such as lack of knowledge, lack of policy support, lack of training, and lack of policy. To limit the negative implications of disclosing situations, the government should develop supportive policies at the national level and organize many initiatives at the hospital level.

Keywords: open disclosure, patient safety incident, health worker, patient safety

Introduction

Errors are common in the healthcare industry.¹ Globally, approximately 42.7 million patients experienced adverse events during hospitalization.² In high-income nations, up to 10% of hospital admissions result in patient harm, and the vast majority are avoidable.³ In developing nations; however, recent estimates suggest that up to 4 out of every 100 individuals die from improper care.³ Published OECD research on patient safety shows that empowering patients to be active participants in treatment could minimize safety failures by up to 15%.⁴ One way to involve patients during their treatment situations is by disclosing patient safety incidents (PSIs). A patient safety incident is any unforeseen event that causes harm or injury to a patient while they are receiving care in a hospital or ambulatory environment.

Open disclosure is an open discussion with patients about incidents that harm them while receiving health care.⁵ The fundamentals of open disclosure are an apology or statement of remorse, an explanation of what actually happened, an opportunity for patients to share their experiences, and an explanation of efforts taken to manage the event and prevent its

recurrence.⁵ It is critical to foster transparency and open disclosure about harmful events with patients, their families, caregivers, and other support people.¹ Research has shown that open disclosure reduces medical lawsuits and related costs, the intention to discipline medical staff, and guilt among medical staff. It can improve the doctor-patient relationship, patient intention to revisit, medical staff recommendations, and assessment scores for quality of care.⁶ Furthermore, exposing medical errors to patients and their families can boost public trust in healthcare providers and institutions.⁷

Countries such as Australia and the UK have made good progress in implementing open disclosure. In 2003, the Australian Commission on Safety and Quality in Health Care mandated Open Disclosure when it published the National Safety and Quality Health Services Standards.⁵ In December 2013, Australian Health Ministers formally adopted the Australian Open Disclosure Framework. This framework addresses open disclosure methods and factors that affect implementation and provides a foundation for nationally consistent communication after unanticipated healthcare outcomes and harm.⁵ The framework was designed for Australian health service organizations in all locations and sectors.⁵ In 2005, the UK National Patient Safety Agency provided the first Being Open guidance. After listening to healthcare and patient representatives on how to strengthen Being Open, they published a revised edition in 2009.⁸ The Framework advises healthcare organizations on how to develop and implement a Being Open policy that is tailored to local organizational needs and ensures the infrastructure is in place to support openness between healthcare professionals and patients, families, and caregivers when harm occurs.⁸ The United Kingdom also has a Duty of Candour and Openness, which is a trust policy for communicating patient safety issues with patients and caregivers. In 2014, through Health and Social Care Act 2008, the Duty of Candour is mandatory for all National Health Service providers registered with the Care Quality Commission.⁹

The Indonesian Minister of Health Regulation Number 11/2017 on Patient Safety states that patients and their families have the right to obtain information about their diagnosis, the procedures of the medical intervention, and its purpose. In addition, alternative courses of action, risks and complications that may occur, the prognosis for the actions taken, and the estimated cost of treatment.¹⁰ This means that if an incident occurs, health staff must make an open disclosure because it is the patient's right. Although open disclosure of patient safety occurrences is an important issue in the healthcare sector, since it can reduce PSIs, research on this topic is scarce in Indonesia. There has not been much research are few studies in Indonesia that investigate health workers' perspectives on PSI disclosure. Health workers' viewpoints on PSI open disclosure must be understood to promote patient safety.

Materials and Methods

Study Design

This study used a mixed-methods explanatory sequential design. We maintained quantitative and qualitative data separately and integrated the results in the interpretation phase to achieve breadth and depth of comprehension and corroboration.¹¹ This strategy is relevant to this research subject and gives detailed data to guide desired interventions. The quantitative phase predominated, and the interviews supplemented the quantitative findings.

Sampling and Data Collection

We used a descriptive study design for the quantitative phase, with data collected via a survey of health personnel who had worked in their hospital for at least one year. The poll used convenience sampling and invited 262 health workers from hospitals to participate in the online survey.¹² We included one item in the questionnaire asking participants if they wanted to be interviewed and to provide email address. We approached 17 people (10% of participants who willing to be interviewed), we purposively choose based on their professions and hospital status in order to obtain a variety of perspectives from the participants. However, we were only able to interview 12 of them, all others declined, citing inability to make time and cancellation on the interview day due to hospital-related matters. Based on a previous study, at least 12 participants is enough to reach data saturation.¹³ Doctors, nurses, midwives, pharmacists, and medical laboratory techs were among the twelve participants included in the qualitative phase.

Study Variables

We examined six variables to assess health workers' perspectives on PSI open disclosure. We assessed the health worker's perspective twice, once using close-ended questions in the quantitative phase and once using open-ended questions in the qualitative phase. The quantitative study variables that described health worker perspectives included: 1) socio-demographic factors; 2) open disclosure practice; 3) open disclosure system; 4) attitude toward open disclosure; 5) attitude toward the open disclosure process; and 6) open disclosure based on the degree of harm caused by events. We collected information about the participant's age, gender, education, occupation, work site, accreditation status, and the number of hospital beds, for socio-demographic questions.

The questionnaire was adapted from previous research.^{6,14} Each question in the "PSI open disclosure systems" category had three options: "yes" (3 points), "no" (2 points), and "don't know" (1 point).¹⁵ In the categories of "attitude toward open disclosure", "attitude toward open disclosure process", "open disclosure according to the level of harm", and "barrier of open disclosure", the responses were "strongly disagree" (1 point), "disagree" (2 points), "neutral" (3 points), "agree" (4 points), "strongly agree" (5 points).¹⁶ The questionnaire passed the Pearson correlation validity test and two items were eliminated. Meanwhile the result for Cronbach's alpha for the reliability tests was 0.767.

We used in-depth interviews to investigate health workers' perspectives. The interview included six open-ended questions concerning health workers' awareness of open disclosure, the necessity of open disclosure, the significance of open disclosure, workplace support for open disclosure, and areas where healthcare professionals may improve their ability to disclose patient safety issues.

Data Collection

We made the survey available online using Google forms, and invited participants to reply.¹² The first author interviewed the participants online using Zoom (Videocommunications Inc, Denver, USA). The interviews were 30–40 minutes long and were conducted in the Indonesian language. Interviews were recorded, with permission, fully transcribed and coded for data analysis. All personal and hospital information was anonymized, and interviewees were given initials.

Data Analysis

The quantitative analysis employed descriptive statistics using SPSS 29. A chi-square analysis was performed to evaluate differences in demographic factors, attitude and open disclosure practices between those who had poor and good open disclosing practices.

We performed chi-square analysis to measure the association between categorical variables: socio-demographics (age, sex, education, occupation, work unit, hospital accreditation status, hospital size); open disclosure system, attitude toward open disclosure, attitude toward open disclosure process, open disclosure according to the level of harm, barrier to open disclosure) and open disclosure practice. The p-value that is less than or equal to 0.05 is referred to as statistically significant or there is a relationship between the categorical variables.

For qualitative data analysis, first, we went over the interview transcripts to find pertinent codes, which we organized into themes. We used thematic analysis to find, assess, and report on similarities or discrepancies.¹⁷ Both data sets were individually evaluated and equally prioritized using convergent parallel design principles. The findings were integrated during the interpretation by discovering relationships or comparing outcomes. As a result, this process can accommodate the diversity of both quantitative and qualitative questions.¹⁸ We have summarized the methods in [Table 1](#).

Results

Quantitative Phase

In all, 262 people took part in the survey. [Table 2](#) shows the descriptive statistics calculated for each item. The majority of survey respondents were female (77.7%), 26–40 years old, (60.8%), held bachelor's degrees (78.9%), and worked as nurses (52.5%). Of the respondents, 39.6% of participants worked in an inpatient unit, 65.7% in a hospital with excellent (Paripurna) accreditation status, and 54.7% worked in a medium-sized hospital with 100–199 beds. Most measures received high marks, including disclosure practice (72.1%), open disclosure system (58.5%), attitude toward open

Table 1 Summary of Methods

Research Phase	Quantitative	Qualitative
Research design	Descriptive	Descriptive
Data collection method	Online survey	In-depth interview
Sampling schemes	Convenience sampling	Purposive sampling
Participants	262 health workers	12 health workers
Inclusion criteria	Health workers working at hospital for at least 1 year	Health workers working at hospital for at least 1 year
Research setting	Hospital	Hospital
Study variables	<ul style="list-style-type: none"> • Socio-demographic characteristics • Open disclosure practice • Open disclosure system • Attitude toward open disclosure • Attitude toward open disclosure process • Open disclosure according to the level of harm resulting from patient safety incident • The barriers to open disclosure. 	<ul style="list-style-type: none"> • Knowledge of open disclosure • The necessity of open disclosure • The importance of open disclosure • Support for open disclosure in the workplace • Areas for improvement.
Data analysis	<ul style="list-style-type: none"> • Close-ended question • Frequency distributions • Chi-square analysis 	<ul style="list-style-type: none"> • Open-ended question • Thematic analysis

disclosure (57.4%), attitude toward open disclosure process (50.2%), open disclosure based on the level of harm caused by PSIs (58.1%), and low barriers to open disclosure (54%). According to the Chi-Square analysis, only the open disclosure system has significant differences based on the perspectives of health workers on disclosing PSIs.

Qualitative Phase

We interviewed 12 people, including doctors, nurses, midwives, pharmacists, and laboratory staff. Most interviewees were female (58.33%), between the ages of 31 and 40 (75%) and employed as doctors (41.67%). Eight (66.67%) of the interviewees worked in hospitals with excellent (Paripurna) accreditation status, while 7 (58.33%) worked in private hospitals, (Table 3). The coding tree diagram is in the Supplementary file (Figure S1). The following are the themes and codes from the interviews:

Theme: Awareness of Open Disclosure

Awareness

Most interviewees had heard about open disclosure of a PSI. However, they were still confused about the differences between incident reporting and incident disclosure. Example responses about awareness include:

“I have seen and heard about it.” (MD 3).

“In terms of incident disclosure, I know from my [postgraduate] class” (MD 4).

The following is an example of confusion:

”I have heard, and indeed, in the hospital, we created a reporting system which all personnel can access by filling out the Google form which is available in all service units or public areas in the hospital.” (MD_1)

Sources

As the responses below show, interview participants learned about open disclosure through socialization, webinar or training:

“It came from socialization.” (MW 1))

Table 2 Socio-Demographics and Variables Measured

Demographic Factors	Number (%)		Chi-square Result
	Poor OD Practice n = 74	Good OD Practice N = 191	
Age			
18–25 years old	12	16	P = 0.13 $\chi^2 = 5.275$
26–40 years old	38	123	
41–55 years old	23	49	
Above 55 years old	1	3	
Sex			
Male	18	41	p = 0.736 $\chi^2 = 0.252$
Female	56	150	
Education			
Senior high school	11	30	p = 0.910 $\chi^2 = 0.434$
Bachelor's degree	58	151	
Master's degree/specialist/consultant	4	7	
Doctorate	1	3	
Profession			
Doctor	5	9	p = 0.220 $\chi^2 = 6.724$
Dentist	0	2	
Nurse	37	102	
Midwife	16	28	
Pharmacist	0	10	
Others	16	40	
Work unit			
Medical Service Units	51	127	p = 0.337 $\chi^2 = 2.173$
Medical Support Units	3	18	
Others	20	46	
Accreditation status			
Basic (Dasar)	8	15	p = 0.501 $\chi^2 = 1.958$
Middle (Madya)	2	3	
Prime (Utama)	20	43	
Excellent (Paripurna)	44	130	

(Continued)

Table 2 (Continued).

Demographic Factors	Number (%)		Chi-square Result
	Poor OD Practice n = 74	Good OD Practice N = 191	
Number of beds in the hospital			
50–99 beds	14	51	p = 0.410 $\chi^2 = 2.883$
100–199 beds	45	100	
200–249 beds	2	10	
> 249 beds	13	30	
Open disclosure system			
Poor	41	69	p = 0.07* $\chi^2 = 8.166$.
Good	33	122	
Attitude toward open disclosure			
Poor	37	76	p = 0.171 $\chi^2 = 2.273$
Good	37	115	
Attitude toward open disclosure process			
Poor	34	98	p = 0.518 $\chi^2 = 0.614$
Good	40	93	
Open disclosure according to the level of harm			
Poor	37	74	p = 0.127 $\chi^2 = 2.776$
Good	37	117	
Barrier to open disclosure			
High	37	85	p = 0.504 $\chi^2 = 0.649$
Low	37	106	

“While participating in a Hospital Accreditation Commission webinar and watching various YouTube videos, I learned about some important materials.” (MD 3)

Concept/Definition

Most participants understood the meaning of open disclosure of PSI and provided a correct definition of incident disclosure:

“How do we reveal this incident, tell the persons concerned, both the patient, the patient’s family, and our superiors?” (MD 4)

Conveying to the patient that what he received was the service he was not supposed to receive and that a component of the service he received was an error by the health worker who supplied the service, whether deliberate or unintentional. (P 1)

Theme: Whether Disclosure is Necessary Disclosure is Necessary

Most participants agreed that disclosure is required, although not all events must be disclosed. According to the participants, it depended upon the type of situation.

Table 3 Interview Participants' Characteristics

Variables	n (%)
Sex	
Male	5 (4.67)
Female	7 (58.33)
Total	12 (100)
Age group	
20–30 years old	1 (8.33)
31–40 years old	9 (75)
41–50 years old	2 (16.67)
Over 50 years old	0 (0)
Total	12 (100)
Occupation	
Nurse	4 (33.34)
Doctor	5 (41.67)
Midwife	1 (8.33)
Medical laboratory technologist	1 (8.33)
Pharmacist	1 (8.33)
Total	12 (100)
Hospital accreditation status	
Not yet accredited	0 (0)
Basic (Dasar)	0 (0)
Middle (Madya)	1 (8.33)
Prime (Utama)	3 (25)
Excellent (Paripurna)	8 (66.67)
Total	12 (100)
Hospital ownership	
Government	5 (41.67)
Private	7 (58.33)
Total	12 (100)

In my perspective, it depends on the incident that occurred, whether for example, the incident caused injury or disability or the prospect of inflicting harm on the patient if there was something very important that was conveyed.

I feel that only sentinel incidents or situations of considerable consequence should be disclosed in terms of disclosure. (MD 2)

Disclosure is Not Necessary

Some participants stated that a near-miss occurrence did not need to be disclosed. Comments included:

For example, if it is just a near miss, something like that does not cause injury, perhaps it just has to be reported, rather than reaching the patient or family, or something like that. (NS 2)

As long as it did not inflict any damage, or it was just a near miss or an unplanned incident, there is no need to reveal this because there was no impact on the patient. All we have to do is report it to the quality committee as a near miss or adverse event without informing the patient. (MD 2)

Theme: Important Factors in Incident Disclosure

Communication Skills

When discussing incidents, interview participants stated that excellent communication is critical.

“When it comes to reporting patient safety, communication is genuinely helpful, that is an important component.” (MD 5)

Communication between health care practitioners and patients, as well as between families and patients. The ethics, how it was presented, because communication failure can lead to misunderstandings and even fatalities. (NS 3)

Type of Incident

According to interviewees, the type of incident is also a crucial component in exposing the incident.

In my opinion, it is vital to consider the sort of incident that occurred since, for example, if it was merely a potential injury condition, that is my opinion or it does not need to be disclosed. We only informed the patient or his or her family about the incident that caused the damage or handicap. (MLT 1)

What is evident is what the incident was, what the impact was, whether there was a short-term or long-term effect on the patient’s body, and why the incident occurred. (MD 3)

Patient & Family Characteristics

Some interviewees stated that patient and family traits are critical because they influence how they respond to situations.

The patient’s and family’s awareness or understanding is critical for us in responding to incident. (MD 1)

Perhaps we can disclose it to patients, but there are some things that the patients themselves may not understand. There could be numerous aspects, such as educational factors or others. (MD 5)

Theme: Support

Policy Support

The majority of interviewees cited a lack of policy support for incident reporting from their hospitals.

I have never seen a relevant policy or standard operating procedure [at the hospital level] involving incident disclosure to patients. (NS 2)

There is not a policy articulating the requirement to disclose incidents, it does not exist yet.” (MD 4)

People

Most participants indicated the existence of support staff in their hospitals for event disclosure.

We already have a complaint management team here. (NS 3)

If an event occurs, there is already a team in place to handle it. (MD 4)

Training

Some interviewees acknowledged the existence of patient safety training, but no emphasis on open disclosure.

Every time we deliver a general orientation or a customized orientation addressing the patient's safety to the new employee, we make that training one of the prerequisites. If it is linked to disclosure, we have not yet held it. (MD 1)

There was never any disclosure training; it was only for reporting. (MLT 1)

Culture

There was disagreement among the interviewees. Some participants mentioned a positive culture, but others reported not being encouraged to report and disclose instances. Example statements include:

The culture of (open disclosure) is supportive. (NS 2)

The (open disclosure) culture is good, but morale and communication skills are often inadequate. (NS 4)

Some examples of unsupportive culture:

The open disclosure culture is not yet supported. We concentrated more on developing a reporting culture. (APT 1)

We are still working on making our workers less scared to report occurrences, which is proving difficult. It's even more difficult to disclose events to patients. (NS 1)

Theme: Things to Improve

Culture

The interviewees believed the culture of open disclosure needs to be improved.

It definitely needs to enhance the culture of open disclosure. (MD 9)

Communication Skills

As mentioned below, communication skills are required to strengthen open disclosure practice:

Effective communication must be improved since, whatever the scenario, we must be able to communicate effectively, both among staff members, internally, and with patients, to avoid an issue later. (MD 3)

I believe that proper communication between medical workers and patients should be improved. (P 1)

Leadership Support

More leadership support is needed:

I believe this requires assistance from the director in addition to (incidents) disclosure. We just want to report those occurrences, but it has not been ideal. (NS 1)

Regulation

According to the interviewees, regulation should also be improved:

First, there must be regulations that protect these health professionals in carrying out medical procedures in hospitals, because as long as there is no regulatory certainty, which is a no-blame culture, I believe the health workers themselves will surely be reported, albeit some will not. (MD 1)

Before we can act, we must first define standard operating procedures. (MD 3)

Discussion

This study revealed several important findings. First, there was a difference between the quantitative and qualitative findings. The survey discovered a high level of open disclosure practice, an open disclosure system, an open disclosure attitude and procedure, and open disclosure based on the severity of harm caused by PSIs. All participants faced minor

obstacles to implementing open disclosure. However, there were considerable discrepancies with the qualitative findings in terms of policy support and whether disclosure is required. According to the survey, most participants' workplaces had an open disclosure policy; yet most interview participants claimed that there was no policy in place for incident disclosures.

The contradictory findings may be a result of lack of awareness of incident disclosure. The interview findings also suggested that participants confused incident reporting and incident disclosure. Trust between the patient and the healthcare professional is a critical component of disclosure.¹⁹ Reporting generally refers only to communicating information to the healthcare administrators by frontline staff, when they discovered or were involved in an unpleasant incident.²⁰ Based on the Australian Open Disclosure Framework, open disclosure involves patients discussing a health care incident that caused harm to them, an apology or declaration of remorse, an explanation of what happened, a chance for patients to share their experiences, and an explanation of attempts to manage and prevent the event.⁵ The survey also revealed that many participants thought minor errors and near misses should be disclosed, but not to patients or caregivers, because it would cause panic and potentially worsen the situation. This is consistent with prior research, which found that only a few physicians considered that patients or carers should be told about near misses.⁶ Another study also stated that nurses believed that if patients did not notice the incidents, a near miss did not necessitate open disclosure of patient safety problems.²¹ They fear that this may erode patients' trust in medical personnel, suggesting that the hospital environment is unsafe. Both quantitative and qualitative assessments agreed that an adverse or sentinel event needed to be communicated. This was similar to a prior study that found that major errors should be reported to patients or caregivers.²² Because a serious error would likely require an intervention, incident disclosure is unavoidable.²¹

Second, our findings indicate that the most important factor in developing a sound disclosure practice is an open disclosure system. In the Indonesian setting, this is conceivable given the hesitant culture and the fact that many hospitals continue to cover the incidences. If a good system already exists, health practitioners will only need to change their attitude toward the system, which will not be difficult. Furthermore, if a good system is already in place, the barriers may be removed.

Third, the important factors in disclosing the incident are effective communication, type of incident, and patient and family characteristics. Effective communication has been linked to patients and nurses prioritizing conformity, and it influences clinical reasoning and the nursing process. It promotes compassionate person-centered care and, when successful, creates favorable patient outcomes and nursing care satisfaction.²³ According to the interview results, good communication, the type of incident, and patient and family characteristics are all critical factors in disclosing the incident.²¹ The participant interviews indicate that patient and family characteristics are crucial because they influence interpretation of the health workers' explanation of the incident.

Patient safety open disclosure training is essential for improving open disclosure practice. Participants are positive about open disclosure training; however, there is training support for patient safety but not for open disclosure. Training for disclosure helps participants to be more confident in disclosing errors to patients.¹⁴ The interview results suggest the culture of open disclosure in hospitals was supportive. However, some interview participants stated that their culture is still not conducive to reporting and disclosing incidents, with several respondents seeing cultural issues as a barrier to system change.²⁴ Cultural change requires strong leadership, which was lacking.²⁴ Patient-centered professionalism and communication skills, and training in delivering bad news, risk management, professional regulation, and policy, can assist healthcare providers in deciding what to reveal, when to disclose it, and how to do so effectively.²⁵ Furthermore, effective transformation requires strong leadership, as well as robust governance systems and accountability. The open disclosure policy can help employees practice safely by identifying and reporting safety incidents, and managing and improving patient safety in a positive learning environment.²⁶ The government must implement policies that make it safe for health workers to disclose incidents. The health facilities should then establish and implement educational programs for staff and patients, form support teams, and improve skills and competencies in incident disclosure. This will lessen the negative consequences of exposing the incident. Referring to other open disclosure guidelines for PSIs, such as those developed in Australia⁵ and the United Kingdom,⁹ will help to develop national guidelines for open disclosure of PSIs that reflect the reality of clinical practice in Indonesia.

To the best of our knowledge, this was the first mixed method study in Indonesia to investigate health workers' perspectives on incident disclosure. The mixed methodologies can provide an in-depth insight into the opinions of health workers. This study has some limitations. According to the survey results, there was a tendency for participants to submit good answers, which may have been due to the bias introduced by the Likert scale, motivating the respondents to produce socially desirable responses that can influence ratings.²⁷

Conclusion

The study's findings shed light on health personnel perspectives on PSI open disclosure in Indonesian hospitals through a mixed methods study. Unlike in other countries, open disclosure is novel for Indonesian health professionals. A good open disclosure system in hospitals could address several issues such as lack of knowledge, lack of policy support, lack of training, and lack of policy. The government should create supporting policies at national level that can be a guidance for hospital to establish good open disclosure system. Educational programs for staff and patients, as well as the establishment of support teams, and the improvement of skills and competences at the hospital level will all help to limit the harmful consequences of disclosing situations.

Ethics and Consent Statement

The Committee of the Faculty of Nursing, Universitas Airlangga, granted the Ethical Approval with the ID number 2598-KEPK. Before taking part in the study, participants provided informed consent included publication of anonymized responses.

Acknowledgments

We thank Universitas Airlangga for providing funding under SATU Joint Research Scheme No 1236/UN3.15/PT/2022.

Disclosure

The authors report no conflicts of interest in this work.

References

1. Donaldson L, Ricciardi W, Sheridan S, Tartaglia R. *Textbook of Patient Safety and Clinical Risk Management*. Springer International Publishing; 2021; doi:10.1007/978-3-030-59403-9
2. World Health Organization. Patient Safety; 2019. Available from: <https://www.who.int/news-room/fact-sheets/detail/patient-safety>. Accessed May 8, 2023.
3. Slawomirski L, Aaraen A, Klazinga N. *The Economic of Patient Safety*; John Wiley & Sons. 2017.
4. Slawomirski L, Aaraen A, Klazinga N. The economics of patient safety in primary and ambulatory care: flying blind. *OECD Health Working Papers*. 2018;106. doi:10.1787/baf425ad-en
5. Australian Commission on Safety and Quality in Health Care. *Australian Open Disclosure Framework*. Australian Commission on Safety and Quality in Health Care; 2013.
6. Pyo J, Choi EY, Lee W, et al. Korean Physicians' Perceptions Regarding Disclosure of Patient Safety Incidents: a Cross-Sectional Study. *PLoS One*. 2020;15(10):e0240380. doi:10.1371/journal.pone.0240380
7. Al Madani R, Al-Rayes SA, Alumran A. Policies vs Practice of Medical Error Disclosure at a Teaching Hospital in Saudi Arabia. *Risk Manag Healthc Policy*. 2020;13:825–831. doi:10.2147/RMHP.S253275
8. NPSA. *Being Open*. NHS; 2009.
9. NHS. *Duty of Candour and Being Open*; 2022.
10. Pasien TK. Menteri Kesehatan Republik Indonesia. *Peraturan Menteri Kesehatan Republ Indones Tahun*. 2017;11:64.
11. Schoonenboom J, Johnson RB. How to Construct a Mixed Methods Research Design. *KZfSS Köln Z Für Soziol Sozialpsychologie. Kolner Z Soz Sozpsychol*. 2017;69(S2):107–131. doi:10.1007/s11577-017-0454-1
12. Tanner K. *Survey Designs. Research Methods*. Elsevier; 2018:159–192. doi:10.1016/B978-0-08-102220-7.00006-6
13. Vasileiou K, Barnett J, Thorpe S, Young T. Characterising and Justifying Sample Size Sufficiency in Interview-Based Studies: systematic Analysis of Qualitative Health Research over a 15-Year Period. *BMC Med Res Methodol*. 2018;18(1):148. doi:10.1186/s12874-018-0594-7
14. Kim C, Mazan JL, Quiñones-Boex AC. Comparison of Community and Hospital Pharmacists' Attitudes and Behaviors on Medication Error Disclosure to the Patient: a Pilot Study. *J Am Pharm Assoc*. 2017;57(2):201–205.e3. doi:10.1016/j.japh.2016.10.008
15. Dhamanti I, Indriani D, Miftahussurur M, Kurniawati E, Engineer CY. Impact of Hospital Readiness on Patient Safety Incidents During the COVID-19 Pandemic in Indonesia: health Worker Perceptions. *BMJ Open*. 2022;12(7):e061702. doi:10.1136/bmjopen-2022-061702
16. Preedy VR, Watson RR. *5-Point Likert Scale. Handbook of Disease Burdens and Quality of Life Measures*. Springer International Publishing; 2010.
17. Braun V, Clarke V. Using Thematic Analysis in Psychology. *Qual Res Psychol*. 2006;3(2):77–101. doi:10.1191/1478088706qp063oa

18. Demir SB, Pismek N, Convergent Parallel A. Mixed-Methods Study of Controversial Issues in Social Studies Classes: a Clash of Ideologies. *Educ Sci Theor Pract*. 2018. doi:10.12738/estp.2018.1.0298
19. Wolf ZR, Hughes RG. Error Reporting and Disclosure. In: Hughes RG, editor. *Patient Safety and Quality: An Evidence-Based Handbook for Nurses*. Advances in Patient Safety. Agency for Healthcare Research and Quality (US); 2008. Available from: <http://www.ncbi.nlm.nih.gov/books/NBK2652/>. Accessed February 2, 2023.
20. Canadian Nurses Protective Society. InfoLAW: reporting & Disclosure of Adverse Events. Canadian Nurses Protective Society; 2022. Available from: <https://cnps.ca/article/reporting-disclosure-of-adverse-events/>. Accessed February 2, 2023.
21. Choi EY, Pyo J, Ock M, Lee SI. Nurses' Perceptions Regarding Disclosure of Patient Safety Incidents in Korea: a Qualitative Study. *Asian Nurs Res*. 2019;13(3):200–208. doi:10.1016/j.anr.2019.05.002
22. Gallagher TH, Waterman AD, Garbutt JM, et al. US and Canadian Physicians' Attitudes and Experiences Regarding Disclosing Errors to Patients. *Arch Intern Med*. 2006;166(15):1605–1611. doi:10.1001/archinte.166.15.1605
23. Afriyie D. Effective Communication Between Nurses and Patients: an Evolutionary Concept Analysis. *Br J Community Nurs*. 2020;25(9):438–445. doi:10.12968/bjcn.2020.25.9.438
24. Duffy A. An Analysis of the Culture in Ireland on Open Disclosure Following Adverse Events in Healthcare. *Clin Risk*. 2012;18(6):217–223. doi:10.1177/1356262212473286
25. Harrison R, Walton M, Smith-Merry J, Manias E, Iedema R. Open Disclosure of Adverse Events: exploring the Implications of Service and Policy Structures on Practice. *Risk Manag Healthc Policy*. 2019;12:5–12. doi:10.2147/RMHP.S180359
26. HSE. Open Disclosure. HSE; 2023. Available from: <https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/open-disclosure/open-disclosure.html>. Accessed February 8, 2023.
27. Smith PB. Response Bias(es). In: Michalos AC editor. *Encyclopedia of Quality of Life and Well-Being Research*. Springer Netherlands; 2014:5539–5540. doi:10.1007/978-94-007-0753-5_2503.

Journal of Multidisciplinary Healthcare

Dovepress

Publish your work in this journal

The Journal of Multidisciplinary Healthcare is an international, peer-reviewed open-access journal that aims to represent and publish research in healthcare areas delivered by practitioners of different disciplines. This includes studies and reviews conducted by multidisciplinary teams as well as research which evaluates the results or conduct of such teams or healthcare processes in general. The journal covers a very wide range of areas and welcomes submissions from practitioners at all levels, from all over the world. The manuscript management system is completely online and includes a very quick and fair peer-review system. Visit <http://www.dovepress.com/testimonials.php> to read real quotes from published authors.

Submit your manuscript here: <https://www.dovepress.com/journal-of-inflammation-research-journal>