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CHALLENGES IN THE IMPLEMENTATION OF PATIENT SAFETY CULTURE IN THE MATERNITY WARD OF HOSPITAL X – A QUALITATIVE STUDY

Tantangan Implementasi Budaya Keselamatan Pasien di Ruang Kebidanan RSUD X– Studi Kualitatif

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ABSTRAK

Keselamatan pasien merupakan komponen kunci dalam menjamin mutu layanan kesehatan, namun penerapannya belum optimal, terutama di ruang kebidanan yang berisiko tinggi terhadap kejadian tidak diinginkan seperti kesalahan prosedur atau keterlambatan penanganan. Di RSUD X, survei budaya keselamatan pasien menunjukkan bahwa dimensi pembelajaran organisasi dan perbaikan berkelanjutan memiliki skor yang lemah dengan hanya 21,9% respons positif. Penelitian ini bertujuan untuk mengeksplorasi tantangan dalam implementasi budaya keselamatan pasien. Metode penelitian menggunakan pendekatan kualitatif dengan metode constructivist grounded theory, data dikumpulkan melalui wawancara mendalam pada sembilan orang responden dengan komposisi lima staf tenaga pelayanan kesehatan, dua staf manejemen bidang umum dan pelayanan medik, satu ketua komite mutu, dan satu pasien kebidanan yang dipilih secara purposive sampling berdasarkan mampu berkomunikasi dengan baik, individu yang kaya informasi dan bersedia diwawancara. Penelitian dilaksanakan pada bulan Desember 2024 hingga Januari 2025 di RSUD X. Analisis data dilakukan dengan tahapan open coding, axial coding dan selective coding, serta triangulasi data dengan observasi dilapangan. Hasil penelitian mengungkap sejumlah tantangan meliputi dilema antara profesionalisme dan konflik kepentingan manajerial, normalisasi kesalahan, kurangnya komitmen manajemen memperburuk kondisi ini, ditambah dengan diskriminasi terhadap pasien, serta kerja tim yang tidak efektif. Selain itu, minimnya pengawasan, serta keterbatasan sumber daya dan kompetensi tenaga kesehatan menjadi hambatan signifikan. Oleh karena itu, diperlukan strategi seperti pelatihan berkelanjutan, reformasi manajemen, serta penguatan kerja tim lintas profesi untuk meningkatkan budaya keselamatan pasien. Implikasi dari penelitian ini dapat memperkuat praktik keselamatan pasien dalam layanan kebidanan dan mendorong perbaikan sistematik pada mutu pelayanan kesehatan ibu dan anak.

Kata kunci: *budaya keselamatan pasien, rumah sakit, tantangan implementasi*

ABSTRACT

Patient safety was a key component in ensuring the quality of healthcare services; however, its implementation remained suboptimal, particularly in maternity wards, which are highly prone to adverse events such as procedural errors or delayed treatment. At Hospital X, a patient safety culture survey revealed that the dimension of organizational learning and continuous improvement scored poorly, with only 21.9% positive responses. This study aimed to explore the challenges in implementing a patient safety culture. A qualitative approach using constructivist grounded theory was employed. Data were collected through in-depth interviews with nine respondents, consisting of five healthcare staff, two hospital managers, one head of the quality committee, and one

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maternity patient. Participants were selected through purposive sampling based on their communication skills, information richness, and willingness to be interviewed. The study was conducted from December 2024 to January 2025 at Hospital X. Data were analyzed through open coding, axial coding, and selective coding, followed by triangulation with field observations. Findings revealed key challenges, including the dilemma between professionalism and managerial conflicts of interest, normalization of errors, lack of managerial commitment, patient discrimination, and ineffective teamwork. Other significant barriers included poor supervision, limited resources, and insufficient staff competence. Therefore, strategies such as continuous training, managerial reform, and strengthening interdisciplinary teamwork were deemed necessary to improve the patient safety culture. The findings have broader implications for enhancing patient safety practices in maternity services and systematically improving the quality of maternal and child healthcare.
Keywords: patient safety culture, hospital, implementation challenges

INTRODUCTION

Patient safety is a system aimed at making healthcare services safer. Hospitals implement internal quality improvement programs that include the measurement and reporting of quality indicators, reporting of patient safety incidents, and risk management [1]. This program also includes periodic evaluation of procedures and the development of policies that support a patient safety culture throughout the organization. This approach is expected to create an environment that is responsive to risks and proactive in minimizing incidents [2]. Patient safety culture is an essential element in healthcare services, reflecting the commitment of healthcare workers to maintain service quality and reduce the risk of adverse incidents [3]. Based on the Guidelines for Reporting Patient Safety Incidents issued by the Hospital Patient Safety Committee, factors influencing patient safety incidents include organization, management, policy, human resources, and the safety culture itself [4]. In the context of hospital management, challenges refer to various obstacles or problems encountered in achieving effective and efficient healthcare service goals. These challenges may involve human resources, infrastructure, regulations, technology, and finances. For instance, shortages of trained medical personnel, limited facilities, dynamic regulatory changes, and budget constraints are among the common challenges faced by hospitals in Indonesia [5].

The implementation of quality improvement programs in hospitals is particularly important in maternity wards, which have a high risk of incidents. An example of an Adverse Event is a pregnant woman experiencing severe bleeding due to an episiotomy procedure error, resulting in the need for surgery and a blood transfusion that should not have been necessary [4]. To reduce such risks, a transparent and easily accessible incident reporting system is needed. This system should include open reporting mechanisms for both near misses and incidents that have occurred, in order to identify root causes and implement continuous improvement [6]. Patient safety regulations are stipulated in the Decree of the Minister of Health No. HK.01.07/MENKES/320/2020, which sets the professional standards for midwives. Midwives are required to understand the philosophy and code of ethics of midwifery to ensure quality services. Midwife competencies include ethics, patient safety, communication, professional development, clinical skills, as well as health promotion and counseling [7]. However, in practice, the fulfillment of these competencies is not yet optimal, particularly in the aspects of incident reporting and learning from mistakes.

In Indonesia, patient safety culture is still considered moderate to low. A study by Armi et al. (2023) identified barriers such as limited understanding of safety principles, lack of training, and insufficient managerial support. Other inhibiting factors include ineffective communication and suboptimal incident reporting systems [8]. However, most previous

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studies have focused on quantitative approaches and have not explored contextual aspects in depth, especially in high-risk units such as maternity wards.

Patient safety culture as a concept reflects the values, norms, and fundamental beliefs within an organization that are disseminated through social interaction [9]. The Agency for Healthcare Research and Quality (AHRQ) measures safety culture based on 12 dimensions, such as management actions in patient safety, teamwork, open communication, feedback on errors, and frequency of event reporting [10]. Evaluation of these dimensions allows hospitals to identify weak aspects and develop targeted improvement strategies [11]. A patient safety culture survey at RSUD X in September–October 2022 showed that the positive response rate across various dimensions was still low. The dimension of organizational learning and continuous improvement scored only 21.9%—far below the minimum recommended standard of 75%. Furthermore, the average patient safety score was only 48.71%. This data indicates a weak culture of learning and continuous improvement, which should be a fundamental foundation in quality improvement [12].

Challenges in implementing a patient safety culture include limited resources and high workload pressures. Studies show that the main barriers are ineffective communication, unclear roles, and lack of support for healthcare workers involved in incidents [13]. In addition, stigma or fear of punishment in reporting incidents is a serious obstacle to creating a safe environment [14]. In preliminary interviews with midwives in the maternity ward, it was found that fear of reporting errors remains high due to social repercussions. One midwife revealed that her colleague who made a medication error experienced psychological pressure and disrupted social relationships, leading many healthcare workers to be reluctant to report similar mistakes. These findings indicate a gap between the expected system and the reality in the field. Previous studies have not extensively explored qualitatively the experiences of healthcare workers in facing such dilemmas, particularly in maternity units.

Therefore, this study aims to analyze the challenges faced by RSUD X in improving the patient safety culture. This study offers novelty in the context of a qualitative approach based on constructivist grounded theory, which explores respondents' experiences in depth in the maternity ward. These findings are expected to contribute to the formulation of contextual and applicable strategies for improving patient safety in maternal and child health services.

METHODS

The research method used in this study was a qualitative method with a Grounded Theory approach. This research was conducted in the maternity ward of RSUD X, from December 2024 to January 2025, over a period of approximately three weeks. In this qualitative study, data collection was carried out through in-depth, unstructured interviews, which flowed according to the respondents' answers but remained within the framework of the research objectives. The interview guide was developed based on the focus and objectives of the study as well as the results of discussions with the Supervisory Committee. The researcher also developed questions based on the respondents' answers during the in-depth interviews. This was done to create a relaxed interview atmosphere so that richer data could be obtained.

Data collection from the first respondent served as a trial to assess the researcher's understanding of qualitative data collection methods. The knowledge and understanding possessed by the researcher would influence the meaning of the data obtained from phenomena observed and heard during the data collection process. Once the researcher felt more attuned and capable in collecting data, the process continued with the next respondents.

The interview process received prior approval from RSUD X, with an average duration of 60 minutes per session. The researcher used a recorder and an observation sheet as

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tools for triangulation. Respondents were selected purposively, resulting in a total of nine respondents, with data saturation reached. The sample selection criteria included the ability to communicate effectively, being information-rich individuals willing to be interviewed, and involvement in the implementation of the patient safety culture. The composition consisted of one inpatient maternity ward staff member, one delivery room (VK) staff member, one head of the inpatient maternity ward, one head of the delivery room, one former head of the delivery room, one quality committee member, two management representatives or director's delegates, and one maternity patient. Potential biases from purposive sampling include selection bias, which may lead the researcher to choose respondents who only support their assumptions, and confirmation bias, which may lead to selecting respondents who reinforce the researcher's initial hypotheses. To mitigate or avoid bias in purposive sampling, the researcher established clear inclusion criteria, involved respondents from various positions and functions, and conducted data triangulation from different respondents and observations.

Ethical considerations followed the principles of respect for persons, beneficence, justice, veracity, confidentiality, and non-maleficence or "do no harm," in accordance with general health research ethics. This study obtained ethical clearance approval from the Health Research Ethics Committee of the Faculty of Medicine, Universitas Brawijaya Malang, with the number 450/EC/KEPK-S2/12/2024.

The variable examined was the challenge in implementing the patient safety culture. The data obtained were analyzed using the grounded theory data analysis method, which included open coding, axial coding, and selective coding processes to identify the main concepts and relationships between concepts. To enhance data validity, triangulation techniques were employed through field observations and multiple respondents. The results of this study are expected to provide in-depth insights into the challenges of implementing the patient safety culture at RSUD X.

RESULT

This study identified various challenges in implementing the patient safety culture at RSUD X. These challenges are grouped into several themes that reflect the complexity of the problems encountered in the field, as shown in Table 1.

Table 1. Thematic Clusters of Challenges in Implementing Patient Safety Culture

Thematic Cluster	Theme	Sub-theme
Challenges in Implementing Patient Safety Culture	Management: Dilemma Between Professionalism and Conflict of Interest	Management authority within the organization is limited by *political will* Conflicts of interest occur everywhere
	Culture of Normalizing Errors	"*Mistakes are normal*" culture Covering up errors in incident cases
	Lack of Commitment Across All Levels of Management	Supervisors provide insufficient evaluation Regulations for conducting monitoring are not yet in place
	Discriminatory Treatment and Poor Communication Toward Patients	Midwives prioritize high-risk patients and tend to neglect normal conditions Hospitals prioritize patients labeled as "VIP" Midwives refuse to explain the patient's condition
	Ineffective Teamwork	Blaming others (*blaming culture*) Interpersonal, team, and unit relationships are'nt harmonious Fear of becoming a *Public Enemy*

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Thematic Cluster	Theme	Sub-theme
	Limited Hospital Resources	Inadequate facilities and infrastructure Insufficient financial compensation Lack of innovation in quality improvement programs No SOP for incident reporting Severe shortage of healthcare workers
	Healthcare Workers' Lack of Focus on Patient Safety Priorities	Lack of attention to detail in service delivery Lack of intrinsic motivation among midwives
	Low Competence of Healthcare Workers	Lack of understanding and awareness regarding incident reporting Difficulty in changing mindset Poor attitude among healthcare workers

Source: Data processed (2025)

Management: Dilemma Between Professionalism and Conflict of Interest

Authority within the organization is limited, while appointments to positions are still based on *political will* rather than competence. This contributes to stagnation in hospital development and turns it into a political tool for certain interests. One respondent stated:

"They (the management) do not think about advancing the hospital; they use the hospital as a political tool... That's the problem why we are not progressing." (R5)

Such practices not only weaken the management system but also impact the hospital's credibility in implementing optimal patient safety programs.

Culture of Normalizing Errors

The habit of allowing mistakes to become routine has taken root, as expressed:

"Maybe because the patient was fine, that's why it wasn't reported. Then, the culture of getting used to something that's wrong. over time, it just becomes normal." (R5)

In addition, there is also a tendency to cover up mistakes in unreported incident cases:

"Yes, just cover it up; after all, nothing happened, they say… The problem is, sometimes even when something does happen, they still try to cover it up—so what about when nothing happens?" (R5)

This practice reflects a weak culture of accountability and evaluation in patient safety.

Lack of Commitment Across All Levels of Management

The lack of clarity in patient safety strategies has also led to the absence of specific indicators to assess the effectiveness of implementation.

"There are no specific indicators to monitor it. For example, whether there's a checklist form, or specific assessment to evaluate whether it's being carried out or not—there's nothing like that." (R8)

"Let alone such items, this hospital doesn't even have a clinical pathway." (R9)

This practice reflects a weak evaluation system and a lack of commitment across all levels of management to ensure the sustainability of the patient safety culture.

Discriminatory Treatment and Poor Communication Toward Patients

Patients with normal conditions often do not receive optimal attention. The hospital also tends to prioritize patients labeled as "VIP" over regular patients, leading to inequity in service delivery.

"High-risk cases like eclampsia usually get more of our attention because there are specific procedures. Meanwhile, others appear safe but that's not always the case"(R9)

"Yesterday there was an important patient who was going to have surgery, and they were prioritized. Yet another patient had been fasting since dawn. " (R3)

Tendency for midwives to be reluctant to explain the patient's condition in detail.

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"Some are curt with patients, speaking only briefly, without providing detailed explanations." (R3)

This situation reflects a lack of adherence to the principle of equity in healthcare services.

Ineffective Teamwork

A strong *blaming culture* still exists in the workplace.

"*As a result, the midwives get scolded, as if the doctors were blaming us because the midwives didn't do things right*." (R1)

Interpersonal relationships within the team are not harmonious and personal tensions that hinder cooperation and collaboration between units.

"*It even comes to fights, exchanging sarcastic remarks... That's why with the schedule, sometimes we ask not to be paired with this person or that person.*" (R2)

"*A few times there were benchmarking visits to hospitals in Java... I was never included, they went by themselves."* (R5)

The fear of becoming a *public enemy* is also a factor that hinders teamwork.

"*It's common... what culture do we have? a culture of shame... the problem is that people are afraid of being blamed if an incident is reported. That might be one of the reasons why someone feels it should be reported but ends up turning a blind eye, rather than becoming the public enemy*" (R5)

Lack of openness and a blaming culture hinder teamwork, weakening the hospital's patient safety culture.

Limited Resources in the Hospital

Infrastructure limitations are part of the hospital's lack of resources.

"The preparation from the ward or equipment doesn't seem ready… We've been planning for PONEK for a long time, but it's still not ready. Every audit, we discuss PONEK, but it's just talk without actual preparation." (R2)

"The problem was that there were two patients scheduled for surgery that day, but only one operating room was available. Then baby bassinet, we've requested this since 2023, but I don't know why they haven't provided it, even though they could buy plenty of beds. It's not just our ward that's lacking, NICU is also short" (R3)

Low financial incentives also hinder the management of healthcare personnel. Some specialist doctors are reluctant to work at RSUD X due to inadequate remuneration.

"That's why no one wants to stay here, especially the specialists." (R5)

The absence of clear flagship programs causes stagnation in improving service quality.

"The problem is we never know what the hospital's flagship programs are… there's no clear direction." (R5)

RSUD X also lacks specific SOPs related to the implementation of a patient safety culture, which hampers systematic incident reporting and handling.

"I've never seen the SOP flow. I also haven't been involved in drafting it." (R8)

The hospital faces shortages of healthcare workers, especially midwives, intensive care staff, and anesthetists. Some specialist doctors are only residents with short-term assignments.

"In a month, staffing is limited because three people are on leave, so sometimes we (midwives) work with just four people a day… sometimes only two OB-GYNs are available, because there's only one anesthetist." (R3)

his lack of resources leads to suboptimal healthcare services, poses risks to patient safety, and increases the workload and stress levels of healthcare workers.

Lack of Focus on Patient Safety Priorities

Inaction documentation that is often inaccurate. Some staff even record the results of actions before the care is actually provided.

"Before the patient arrives, we've already written it down, just need to add the doctor's advice and the actions, so there's not much to do.." (R3)

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Patient identification is often carried out inaccurately, with staff only confirming the patient's name without further verification, leading to the risk of incorrect procedures.

"Sometimes there are patients with similar identities, and they take the wrong blood sample—luckily it wasn't given to the patient." (R1)

"In patient identification as well… that's the shortcoming of our colleagues here; identification is only by asking 'Is this you, ma'am?' whereas it should include three identifiers (name, date of birth, address)." (R3)

Low intrinsic motivation also impacts service quality.

"There's no passion for their work, very little.." (R5)

"When providing services, the important thing is that my task is done, so I can go home. That's it. Whereas, there are actually many aspects that we should be paying attention to." (R7)

This lack of focus on patient safety results in suboptimal healthcare services at RSUD X and increases risks for patients.

Lack of Competence Among Healthcare Workers

Incident reporting remains very limited.

"During accreditation we keep emphasizing it, and yes, they report incidents for the first few months, maybe six months, but after that it disappears and nothing gets reported anymore." (R5)

A narrow and defensive mindset toward criticism is a major barrier to driving change.

"For those with a growth mindset, when they are reported, they see it as a push to become better… but mostly people are narrow-minded, not open-minded… when reported, they feel like they're being targeted for mistakes, which leads to resentment… mostly in Indonesia people are narrow-minded… that's the prevailing paradigm." (R5)

Fear of consequences or punishment, reflecting weak attitudes toward patient safety.

"Sometimes our colleagues are afraid to report incidents, afraid of receiving punishment." (R7)

Without more intensive training, a shift in mindset, and a strong commitment to a patient safety culture, these challenges will continue to impact the quality of hospital services.

Interaction Between Themes

Thematic analysis revealed clusters of challenges in implementing a patient safety culture in the maternity ward of RSUD X, reflecting various systemic barriers. Challenges stem from management dilemmas in balancing professionalism with conflicts of interest in the workplace. The normalization of errors without systematic evaluation exacerbates the situation, increasing the risk of repeated incidents. Furthermore, limited resources directly impact team effectiveness and weaken management's commitment to building a patient safety culture. Team ineffectiveness is further compounded by the low competence of healthcare workers, who tend to focus more on completing routine tasks than on applying patient safety principles. Consequently, discriminatory behavior and poor communication with patients emerge, contributing to decreased service quality and increased patient safety risks.

In Figure 1, it is explained that the challenges in building a patient safety culture stem from management dilemmas in balancing professionalism and conflicts of interest. The culture of normalizing errors worsens the situation due to the lack of systematic evaluation and improvement. Limited hospital resources affect the effectiveness of teamwork, while a lack of management commitment weakens patient safety efforts. In addition, the low competence of healthcare workers leads to a greater focus on routine tasks rather than patient safety principles. Consequently, discriminatory behavior and poor communication with patients may arise, which can reduce service quality and increase the risk of patient safety incidents.

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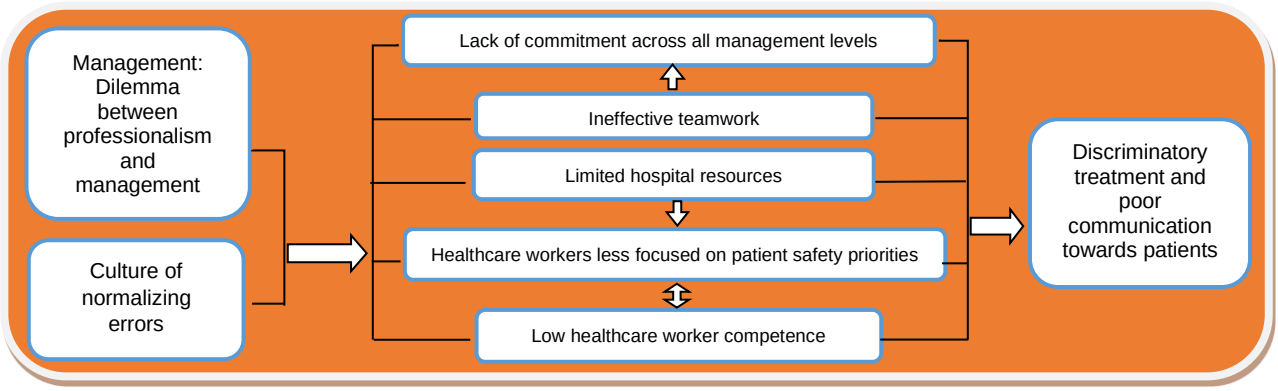

Figure 1. Interaction Between Themes

DISCUSSION

Challenges in Implementing a Patient Safety Culture

A patient safety culture is a combination of values, attitudes, competencies, and behaviors of individuals and groups within a healthcare organization [15]. In practice, the implementation of a patient safety culture faces various complex and multidimensional challenges. Wahyuda et al. (2024) identified several key barriers, such as a lack of leadership support, poor teamwork, ineffective communication, limited human resources, a blame culture, and suboptimal incident reporting [16].

This study found challenges consistent with those findings, including management dilemmas between professionalism and conflicts of interest, a culture of normalizing errors, weak management commitment, discrimination in patient care, ineffective teamwork, limited hospital resources, low focus of healthcare workers on patient safety, and a lack of healthcare worker competence.

Management: Dilemma between Professionalism and Conflict of Interest

Conflicts of interest in hospital management can hinder the implementation of a patient safety culture. Permana et al. (2024) state that professionalism requires high competence, integrity, and objectivity, yet conflicts of interest can disrupt the independence of decision-making [17].

This study found that managerial appointments at RSUD X were more influenced by political will than by relevant professional backgrounds. As a result, management lacked the authority to execute strategic decisions, such as evaluating the patient safety culture. Therefore, to address this issue, transparency, accountability, and the involvement of external auditors in hospital oversight are necessary.

The Culture of Normalizing Errors

Normalizing errors is a phenomenon in which improper behavior is considered acceptable within the work environment [18]. The findings of this study indicate that midwifery staff regarded mistakes as normal.

This culture may emerge because individuals seek acceptance within their work environment. Therefore, education plays a crucial role in fostering awareness and accountability for patient safety, alongside a stricter evaluation system to prevent the perpetuation of such a culture.

Lack of Commitment Across All Levels of Management

Weak management commitment can lead to a low prioritization of patient safety, the absence of clear policies, and minimal resource allocation [19]. Mistri et al. (2023) emphasized that when management fails to demonstrate commitment, staff tend to neglect patient safety [20].

This study found that at RSUD X, management did not provide adequate support for the implementation of a patient safety culture. The absence of written monitoring and evaluation resulted in a lack of follow-up on recommendations for improving patient

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safety. Therefore, leadership system reform that prioritizes a patient safety–based approach and continuous performance evaluation is urgently needed.

Discriminatory Treatment and Poor Communication with Patient

The WHO (2021) states that discrimination in healthcare services can reduce patient trust and increase the risk of medical errors [21]. Alhur et al. (2024) further highlight that poor communication contributes to errors in therapeutic decision-making [22].

At RSUD X, discrimination occurred when midwives prioritized VIP patients over those in more urgent condition. Poor communication was also observed, particularly in interactions between midwives and patients' families. Therefore, training in empathetic communication skills and the implementation of patient-centered care principles are necessary to address these issues.

Ineffective Teamwork

Poor collaboration within a team can lead to miscommunication, errors in decision-making, and low coordination in patient care [22]. Alharbi et al. (2024) state that misunderstandings regarding roles and responsibilities within the medical team increase the risk of medical errors [23].

The study found that relationships among healthcare workers at RSUD X were not harmonious, with frequent conflicts arising from personal issues and difficulty mobilizing colleagues within the team. A blame culture between professions was also observed, where doctors blamed midwives, and midwives blamed each other for errors that occurred. Therefore, to improve teamwork, interprofessional collaboration programs, a work environment that supports psychological safety, and continuous team communication training are needed.

Limited Hospital Resources

Resource constraints can lead to increased workload, delays in patient care, and a decline in the quality of care[24]. A shortage of medical personnel and inadequate facilities are key factors affecting the implementation of patient safety. A study conducted by Looi et al. (2024) emphasized that healthcare facilities lacking infrastructure and medical staff are more likely to experience an increased risk of medical errors and patient safety incidents[25].

This study found that RSUD X faced shortages of consumables, limited access to operating rooms, and the absence of optimal Emergency Obstetric and Neonatal Care (PONEK) services. The situation was further exacerbated by low incentives for healthcare workers, particularly specialist doctors, which negatively impacted their attendance and involvement in maternity services. This is consistent with the findings of Anesti et al. (2022), who stated that inadequate compensation contributes to low motivation and clinical performance[26]. Additionally, budget constraints have led to limited availability of medical technology and regular training for healthcare workers, despite evidence showing that continuous training significantly reduces the risk of incidents[27]. Staffing shortages have also resulted in burnout among existing staff, which, according to WHO (2023), contributes to decreased alertness and patient safety[28]. A study in type C hospitals in Indonesia by Hasibuan et al. (2022) also demonstrated that a non-ideal health worker ratio correlates with an increase in unreported incidents[29].

Therefore, long-term strategies that include increasing budget allocations, implementing workload-based human resource planning, and reforming incentive policies need to be urgently pursued [30]. The digitalization of resource management systems is also a crucial step toward ensuring efficiency and transparency in hospital logistics distribution. Efforts to strengthen resource capacity will not only enhance the culture of patient safety but also increase public trust in hospital services [31].

Lack of Focus on Patient Safety Priorities

High workload and lack of training can reduce healthcare workers' vigilance toward

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patient safety [32]. Non-compliance with SOPs often occurs due to a lack of understanding of the importance of these procedures.

Midwives at RSUD X do not always follow SOPs, often perform inaccurate documentation, and are less meticulous in medication administration and patient identification. Low intrinsic motivation also affects the quality of services, where some midwives are more oriented toward financial compensation than patient safety. Therefore, continuous training and increased supervision of SOP compliance are steps that must be implemented.

Low Competence of Healthcare Workers

The competency standards for healthcare workers include clinical skills, ethics, communication, and risk management (KEPMENKES No. HK.01.07/MENKES/320/2020). However, limited training and high workloads are often obstacles in developing healthcare workers' competencies [7].

The study found that in RSUD X, many midwives lacked awareness in reporting incidents, had difficulty changing their mindset, and demonstrated unprofessional attitudes at work, as staff preferred to resolve issues informally. Therefore, improving the competence of healthcare workers can be carried out through collaborative governance, more intensive training, and a more transparent incident reporting system free from excessive sanctions. By addressing these challenges systematically, it is expected that the patient safety culture in RSUD X can be significantly improved.

Strengths and Limitations of the Study

This study provides an important contribution in mapping the actual barriers in the maternity ward and recommending improvement strategies through continuous training, accountability-based managerial reforms, as well as strengthening reporting systems and interprofessional collaboration.

This study is limited to a single hospital and did not involve longitudinal observation. Future studies may explore management policy–based interventions, compare high-risk units, and use a quantitative approach to measure the effectiveness of patient safety strategies.

CONCLUSION

This study identified challenges in implementing a patient safety culture in the maternity ward of RSUD X using a constructivist grounded theory approach. The main challenges include dilemmas of professionalism, conflicts of interest, normalization of errors, lack of management commitment, poor communication, ineffective teamwork, limited resources, and low competence of healthcare personnel. To strengthen the safety culture, it is necessary to implement organizational learning and continuous improvement through reflection, evaluation, training, certification, mentoring for new staff, as well as a zero-tolerance policy for safety violations supported by management commitment and learning-oriented leadership.

Optimization of human resources can be achieved by balancing the staff-to-patient ratio, allocating budgets for regular training, and providing psychological support for healthcare workers. Improvements in communication and teamwork can be achieved through cross-team coordination and the elimination of silo mentality. Digitalization of incident recording and reporting based on applications or web platforms needs to be developed for reporting effectiveness. Further research is recommended to explore psychological and social factors, test the effectiveness of policy or technology interventions, and conduct comparative analyses between hospitals to identify factors for successful implementation of patient safety culture.

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