

Knowledge, Attitudes, and Practices Regarding Patient Safety Incident Reporting Among Tertiary Hospital Healthcare Workers: A Cross-Sectional Study

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Abstract

Background: Patient safety incident reporting is a critical component of patient safety systems; however, underreporting remains a persistent challenge in many healthcare settings. Although the knowledge and attitudes of healthcare workers toward reporting are studied, their relationship with actual reporting practices remains unclear.

Objectives: To describe knowledge, attitudes, and practices (KAP) regarding patient safety incident reporting, and to investigate factors associated with reporting practices among healthcare workers in a tertiary hospital in Vietnam.

Methods: This cross-sectional study involving 280 healthcare workers was conducted in a tertiary hospital in Vietnam. A structured questionnaire assessing KAP related to patient safety incident reporting was used to collect; practice was evaluated only among participants with prior reporting experience. Participant characteristics and KAP levels were summarized using descriptive statistics. Spearman correlation was used to examine the relationships between continuous variables and practice scores, whereas chi-square or Fisher exact tests were used to assess the associations between categorical variables and reporting practices.

Results: Of the 280 participants, 41.1% demonstrated good knowledge and 84.6% showed positive attitudes toward patient safety incident reporting, with only 51.1% having ever reported a patient safety incident. Among the 143 participants with reporting experience, 61.5% demonstrated appropriate reporting practices. No significant associations were found between reporting practices and age, work experience, knowledge, or attitudes ($P > .05$). Gender was the only factor that was significantly associated with reporting practices ($P = .04$).

Conclusions: Despite having positive attitudes, knowledge gaps and suboptimal reporting practices persist among healthcare workers. The lack of association between knowledge, attitudes, and reporting practices suggests that system-level factors play a more important role than individual awareness. Interventions should focus on improving practical training, strengthening reporting systems, and fostering a nonpunitive reporting culture to enhance patient safety.

Keywords: Patient safety, Incident reporting, Knowledge, Attitude, Practice, Healthcare workers

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Introduction

Patient safety is a fundamental component of healthcare quality and has gained increasing global attention over the past decades.¹ Despite significant advances in medical science, healthcare delivery remains complex and inherently risky, resulting in unintended harm to patients during care processes. Patient safety incidents are events or circumstances that could have unnecessarily harmed patients. These events continue to pose a significant global challenge and undermine the fundamental mission of healthcare systems to protect patient health and life.^{2,3}

Patient safety incidents occur in approximately 10% of hospitalized patients globally, with higher rates reported in low- and middle-income countries.⁴ A substantial proportion of these events are preventable, and many are associated with serious consequences, including prolonged hospitalization, disability, and death.⁵ Recent evidence from the World Health Organization indicates that unsafe care continues to represent a major global health challenge, highlighting the urgent need for effective patient safety interventions.^{4,5}

Beyond clinical consequences, patient safety incidents impose a considerable economic burden because of prolonged hospital stays, increased treatment costs, and medico-legal claims.⁶ These events also negatively affect healthcare providers, often referred to as “second victims”, who may experience psychological distress, professional repercussions, and legal consequences.⁷ Healthcare institutions face reputational damage and loss of public trust.⁸ Therefore, improving patient safety is a clinical priority and a strategic imperative for healthcare systems.

Incident reporting systems are a cornerstone of patient safety improvement. By systematically capturing information on patient safety incidents, errors, and near-miss incidents, these systems enable healthcare organizations to identify system vulnerabilities and implement preventive strategies. However, the effectiveness of incident reporting systems depends on their availability and their implementation in routine clinical practice. Effective reporting systems typically require clear reporting procedures, accessible reporting channels, timely feedback mechanisms, and organizational support for learning from reported incidents.⁵ Previous studies have shown that reporting systems are often underutilized when healthcare workers perceive reporting processes as time-consuming, receive limited feedback, or fear blame and punitive consequences.^{9, 10} Consequently, a reporting system alone may be insufficient to ensure active reporting and organizational learning. Notably, near-miss events, although not resulting in patient harm, provide valuable opportunities for organizational learning and quality improvement.¹¹ However, underreporting of patient safety incidents remains a persistent global issue, limiting the effectiveness of reporting systems.

Multiple factors contribute to underreporting, including insufficient knowledge of reporting procedures, lack of feedback, time constraints, and a prevailing culture of blame and punishment.^{9,10} Healthcare workers may fear disciplinary actions, legal consequences, or negative evaluation, which discourages transparent reporting.¹² While healthcare professionals generally recognize the importance of incident reporting, actual reporting practices are often inconsistent and inadequate.¹³⁻¹⁵ Importantly, discrepancies between knowledge, attitudes, and practices (KAP) have been frequently reported, suggesting that positive awareness and attitudes do not necessarily translate into appropriate reporting behaviors.¹⁵

Previous studies examining healthcare workers' KAP in Vietnam have primarily focused on reporting adverse drug reactions and pharmacovigilance systems.^{16, 17}

Although these studies provide valuable insights into medication-related safety reporting, evidence regarding healthcare workers' KAP toward broader patient safety incident reporting remains limited. Patient safety incidents encompass a wider range of events, including clinical errors, near misses, procedural incidents, and system-related failures, which may involve different reporting processes, organizational factors, and behavioral determinants. Furthermore, few studies have explored factors associated with reporting practices in tertiary hospital settings, where complex clinical care and high patient acuity may present unique challenges for incident reporting.¹⁸

This study was conducted in a tertiary-level public hospital in central Vietnam, which manages a high volume of critically ill patients and complex medical cases. The demanding clinical environment, which is characterized by high workload and time-sensitive interventions, may increase the risk of patient safety incidents. However, evidence regarding the KAP of healthcare workers toward incident reporting in such settings remains limited. Therefore, this study aimed to assess the KAP of healthcare workers regarding patient safety incident reporting and to identify factors associated with reporting practices in a tertiary hospital setting in Vietnam. The findings of this study are expected to provide evidence for developing targeted interventions to improve reporting behaviors and enhance patient safety.

Methods

Participants and Setting

A cross-sectional descriptive study with analytical components was conducted between April and October 2025 among healthcare workers in a tertiary-level public hospital in central Vietnam. Eligible participants were healthcare workers who were present at the hospital during the study period and agreed to participate. Healthcare workers who were on leave, on external assignments, or unavailable during data collection were excluded from the study.

The required sample size was calculated using a single population proportion formula: $n = [z_{1-\alpha/2}^2 \times p(1 - p)]/d^2$, where n is the minimum required sample size; $z_{1-\alpha/2}^2$ is equal to 1.96 for a 95% confidence level; p is equal to 0.821, based on the proportion of healthcare workers with good reporting practices reported in a previous study on knowledge, attitudes, and behaviors regarding patient safety incident reporting conducted at Tu Du Hospital in Vietnam;¹⁹ and d is equal to 0.05 as the acceptable absolute margin of error. The calculated minimum sample size was 226 participants. The final sample size was set at 280 healthcare workers to compensate for potential nonresponse and incomplete questionnaires.

A convenience sampling approach was employed to invite healthcare workers from multiple departments across the hospital to participate, capturing a range of professional groups and clinical settings. The hospital employed 729 healthcare workers during data collection. Altogether, 300 questionnaires were distributed to eligible healthcare workers. Of these, 280 completed questionnaires were returned and included in the final analysis, resulting in a response rate of 93.3%.

Instruments

Data were collected using a structured, self-administered questionnaire developed based on a comprehensive review of existing literature and national guidelines on patient safety incident reporting. The instrument was adapted from previous studies assessing healthcare workers' KAP related to incident reporting, as well as the Vietnamese Ministry of Health's regulations on patient safety.²⁰

The questionnaire consisted of 4 domains including sociodemographic characteristics (age, gender, professional role, education level, and years of experience).

Knowledge consisted of 15 items designed to assess the understanding of healthcare workers regarding patient safety incident reporting. The items covered the key aspects of patient safety incidents and reporting procedures, including the definition and identification of patient safety incidents; the objectives and importance of patient safety incident reporting; reporting procedures and workflows within healthcare facilities; immediate actions when an incident involving patient safety is recognized; responsible personnel; the classification of patient safety incidents based on severity levels; and the recognition of reportable patient safety incidents, particularly serious events requiring mandatory reporting. Among these, 8 items were single-best-answer multiple-choice questions. The original multi-item question on mandatory reportable events was separated into 7 independent items, each representing a specific scenario (eg, wrong-site surgery, retained surgical items, equipment-related incidents, patient falls, and nonclinical environmental issues). This restructuring ensured scoring consistency and improved measurement reliability. Each correct answer was assigned 1 point, whereas the incorrect or "do not know" responses were scored as 0. The total knowledge score ranged from 0 to 15, with higher scores indicating better knowledge. The scoring method and cutoff point were based on a previous Vietnamese study, in which a score of $\geq 75\%$ of the total (equivalent to ≥ 11.25 points) was classified as good knowledge, while scores below this threshold were considered insufficient knowledge.¹⁹

The attitude domain consisted of 18 items designed to assess the attitudes of healthcare workers toward patient safety incident reporting. The questionnaire captured the multiple dimensions of reporting attitudes, such as 1) perceived responsibility for reporting patient safety incidents; 2) willingness to report promptly and proactively, including near-miss events; 3) adherence to reporting principles, including accuracy, transparency, and nonblaming culture; 4) collaboration with colleagues in identifying the root causes of patient safety incidents; 5) perceived benefits of reporting, including learning, prevention of recurrence, and improvement of patient care; and 6) perceived barriers and negative beliefs toward reporting, including lack of responsibility, lack of managerial support, perceived ineffectiveness, increased workload, time constraints, and beliefs that only certain types of events should be reported. Each item was measured using a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). Negatively worded items (items 13-18) were reverse-coded before analysis to ensure that higher scores consistently reflected more positive attitudes toward incident reporting of patient safety incidents. The overall attitude score was calculated as the mean of the 18 items, with higher scores indicating more positive attitudes. Based on a predefined cutoff point derived from previous studies, a mean score ≥ 3.41 was classified as positive attitude, whereas a score < 3.41 was classified as less favorable attitude.¹⁹

The practice domain assessed the patient safety incident reporting behaviors of healthcare workers using a structured questionnaire with a conditional design. First, the participants were asked whether they had ever reported a patient safety incident (yes/no). Those who responded "yes" were further asked to complete 3 items evaluating their reporting practices in different clinical scenarios. Participants who had never reported a patient safety incident were not assessed for practice behaviors. The 3 items covered key reporting situations, including: 1) near-miss events that were detected and prevented before causing harm; 2) incidents resulting from noncompliance with hospital procedures or regulations; and 3) serious patient safety incidents causing death or significant harm to patients. Each item was measured on a 5-point Likert scale, ranging from 1 (never) to 5 (always). The overall

practice score was calculated as the mean of the 3 items, with higher scores indicating better reporting practices. Based on a predefined cutoff point, a mean score ≥ 3.41 was classified as good practice, while a score < 3.41 was considered inadequate practice.¹⁹ Practice-related items were administered only to participants who had previously reported a patient safety incident, as these items assessed behaviors during the incident reporting process.

The mean item scores for the attitude and practice domains were calculated using a 5-point Likert scale. The mean score was interpreted on the basis of equal interval classification on the scale, with an interval width of 0.8 calculated as $(5 - 1)/5$. Accordingly, the mean scores were categorized as follows: 1.00-1.80 (very negative/inappropriate), 1.81-2.60 (negative/inappropriate), 2.61-3.40 (neutral), 3.41-4.20 (positive/appropriate), and 4.21-5.00 (very positive/ very appropriate). Consistent with previous research, participants with mean score ≥ 3.41 were classified as having positive attitudes or good practice.¹⁹ Experts in patient safety and clinical management reviewed the initial version of the questionnaire to ensure content validity. A pilot test was conducted among 30 healthcare workers to assess clarity and feasibility. Internal consistency was assessed using the appropriate reliability coefficients for each domain. For the knowledge domain, the KR-20 value was 0.74. Cronbach α values were 0.87 and 0.70 for the attitude and practice domains, respectively.

The final instrument was contextually adapted to align with the national patient safety guidelines and institutional reporting procedures in Vietnam.

Data Collection

Data were collected using self-administered questionnaires. Eligible healthcare workers were invited to participate through department coordinators. The questionnaires were independently completed during appropriate departmental times, such as departmental meetings or work breaks, to minimize clinical activity disruptions. Participation was voluntary and confidential. The data collectors were trained as members of the hospital's quality management unit and followed a standardized data collection procedure. The completed questionnaires were checked onsite for completeness before collection. Any missing or unclear responses were immediately clarified with the participants. Daily data checks were performed to ensure data quality.

Statistical Analysis

Data were analyzed using SPSS, version 26.0 (IBM Corp). Participant characteristics and study variables were summarized using descriptive statistics, including frequencies, percentages, and means (SDs). Associations between categorical variables and reporting practices were examined using chi-square or Fisher exact tests, as appropriate. Spearman rank correlation was used to assess relationships between continuous variables and reporting practice scores because the variables were not normally distributed. $P < .05$ was considered statistically significant.

Results

Altogether 300 questionnaires were distributed to eligible healthcare workers, and 280 completed questionnaires were returned and included in the analysis, yielding a response rate of 93.3%. The majority were male (57.9%), with a mean (SD) age of 41.2 (11.2) years. Nurses accounted for the largest proportion (51.1%), followed by physicians and technicians. Most participants (81.8%) had more than 5 years of work experience (Table 1).

Only 41.1% of participants demonstrated good knowledge of patient safety incident reporting, with a mean (SD) score of 11.02 (1.67) (range 6-14). The participants showed relatively high awareness of key concepts such as identifying patient safety incidents and reporting responsibilities, whereas knowledge related to reporting procedures, severity classification, and higher-level reporting requirements was less adequate (Table 2).

The majority of participants (84.6%) had positive attitudes toward patient safety incident reporting, with a mean (SD) attitude score of 3.65 (0.21) (range 3.22-4.28). However, only 51.1% had ever reported a patient safety incident. Among the 143 participants with reporting experience, 61.5% demonstrated appropriate reporting practices, with a mean (SD) practice score of 3.62 (0.57) (range 2.0-5.0) (Table 3).

Attitude was assessed using a 5-point Likert scale and categorized on the basis of the mean score; scores ≥ 3.41 were considered positive attitudes. No negative attitudes (poor or very poor) were observed among the participants. Practice was assessed using a 5-point Likert scale and categorized on the basis of the mean score; scores ≥ 3.41 were considered appropriate reporting practices.

Factors associated with the reporting practices were determined. The Spearman correlation analysis indicated no significant relationships between reporting practices and age, work experience, knowledge, or attitude scores (all $P > .05$). In contrast, a significant association was observed between gender and reporting practices ($\chi^2 = 4.26$, $P = .04$), whereas no significant associations were found for occupation or educational level (Table 4).

Table 1. Characteristics of the Participants

Characteristic	No. (%)
Gender	
Male	162 (57.9)
Female	118 (42.1)
Age, y	
< 30	62 (22.1)
31-40	81 (28.9)
41-50	63 (22.5)
51-60	74 (26.5)
Occupation	
Nurse	143 (51.1)
Physician	70 (25.0)
Technician	57 (20.3)
Others*	10 (3.6)
Educational level	
Diploma	101 (36.1)
University	151 (53.9)
Postgraduate	28 (10.0)
Work experience, y	
< 3	18 (6.4)
3-5	33 (11.8)
> 5	229 (81.8)

* Pharmacists and technicians of biomedical equipment.

Table 2. Knowledge of Patient Safety Incident Reporting

Category	Value
Level of knowledge, No. (%)	
Good	115 (41.1)
Insufficient	165 (58.9)
Correct responses for knowledge items, %	
Identification of patient safety incidents	80.0
Responsible reporter	80.0
Definition of patient safety incidents	78.6
Reporting NC0-NC1*	78.6
Purpose of reporting	77.1
Reporting procedure	61.4
Severity classification	52.5
Reporting NC2-NC3*	49.3
Mandatory reportable events	
Retained surgical items	91.4
Wrong-site surgery	91.1
Wrong procedure	90.7
Fire/explosion incidents	90.0
Patient fall	67.9
Environmental damage	44.6
System failure (electricity/water)	39.3

* NC is the classification of patient safety incidents based on the severity of harm and its impact on patient health and survival, where NC0 indicates no harm or near miss; NC1 indicates mild harm; NC2 indicates moderate harm; and NC3 indicates severe harm or life-threatening events, including death.

Table 3. Attitudes and Practices Toward Patient Safety Incident Reporting

Variable	No. (%)
Attitude category	
Positive	237 (84.6)
Negative	43 (15.4)
Practices for patient safety incidents	
Yes	143 (51.1)
No	137 (48.9)
Correct reporting practices (n = 143)	
Correct (score ≥ 3.41)	88 (61.5)
Incorrect (score < 3.41)	55 (38.5)

Table 4. Factors Associated with Reporting Practices

Variable	No. (%)		Statistics	P Value
	Correct Practice	Incorrect Practice		
Age	NA	NA	-0.04	.61 ^a
Work experience	NA	NA	-0.14	.11 ^a
Knowledge	NA	NA	-0.00	.98 ^a
Attitude	NA	NA	-0.03	.70 ^a
Gender				
Male	57 (64.8)	26 (47.3)	4.26	.04 ^b
Female	31 (35.2)	29 (52.7)		
Occupation				
Nurse	41 (46.6)	28 (50.9)	1.09	.78 ^b
Physician	24 (27.3)	16 (29.1)		
Technician	19 (21.6)	10 (18.2)		
Others [*]	4 (4.5)	1 (1.8)		
Educational level				
College	25 (28.4)	22 (40.0)	2.07	.36 ^b
University	52 (59.1)	27 (49.1)		
Postgraduate	11 (12.5)	6 (10.9)		

Abbreviation: NA, not applicable.

^{*} Pharmacists and technicians of biomedical equipment.

^a Spearman rank correlation.

^b Chi-square test.

Discussion

This study provides important insights into healthcare workers' KAP regarding patient safety incident reporting in a tertiary hospital setting in Vietnam. Overall, the findings revealed a notable discrepancy between knowledge, attitudes, and actual reporting practices. Although attitudes toward reporting were largely positive, knowledge levels were suboptimal, and reporting practices remained inconsistent. Similar discrepancies between awareness and actual reporting behavior have been widely documented.^{21, 22} This pattern has also been confirmed in systematic reviews across different clinical settings.¹³ Furthermore, no significant associations were observed between knowledge, attitudes, and reporting practices, except for gender, highlighting the complexity of factors influencing reporting behavior.^{10, 23}

The proportion of healthcare workers with good knowledge in this study was lower than that reported in previous Vietnamese studies, such as the study conducted at Tu Du Hospital.¹⁹ This is more likely to reflect differences in implementation context than differences in measurement. Healthcare workers may be regularly exposed to the general concept of patient safety incident reporting but less consistently trained or updated on operational details, such as reporting procedures, severity classification, and reportable system-related incidents. In addition, participants demonstrated a strong knowledge of obvious and severe patient safety incidents (eg, wrong-site surgery and retained surgical items) but showed a limited understanding of reporting procedures, severity classification, and system-related incidents.²⁴ Previous research has shown that healthcare workers tend

to recognize severe clinical errors more easily than system-related or near-miss events.⁹ Similar findings have also been reported among nurses regarding a limited understanding of reporting processes.¹⁴ This suggests that knowledge gaps are more pronounced in procedural and system-based aspects than in basic conceptual awareness.

In contrast, attitudes toward patient safety incident reporting were highly positive, with 84.6% of participants demonstrating favorable attitudes. This finding is consistent with previous studies showing that healthcare professionals generally support reporting systems and patient safety initiatives.¹⁵ Similar positive perceptions have also been observed among nurses in acute care settings.¹² However, the relatively high mean score and narrow variability observed in this study suggest a potential ceiling effect, reducing the ability of attitude to discriminate between different levels of reporting behavior. Previous research has noted that uniformly positive attitudes may not necessarily translate into improved reporting practices.²¹

Despite positive attitudes, actual reporting practices remained suboptimal. Only about half of the participants reported having previous experience with patient safety incident reporting; among those with reporting experience, only 61.5% demonstrated appropriate practices. This result is lower than that reported in the Tu Du Hospital study.¹⁹ Differences in study settings may partly explain this discrepancy, as tertiary hospitals with diverse clinical specialties and higher workload may face more reporting barriers. Systematic reviews have also highlighted substantial variability in reporting practices across healthcare settings.¹³ Variations in measurement tools and definitions of “correct practice” may contribute to differences across studies.

This study's key finding is that neither knowledge nor attitudes were significantly associated with reporting practices. This suggests that individual-level factors such as knowledge or perceptions do not solely determine reporting behavior. Similar findings have been reported in large-scale reviews.¹⁰ Instead, system-level factors, such as organizational culture and perceived consequences are often more influential.² The fear of blame and lack of feedback have been identified as major barriers.⁹ Concerns about professional and organizational consequences play an important role.⁸ In addition, psychological distress following patient safety incidents may discourage reporting behavior.²⁵ This effect is further supported by evidence on the “second victim” phenomenon.⁷

In contrast, this finding is inconsistent with some studies. A study in Timor-Leste showed significant relationships among KAP regarding adverse drug reaction reporting of healthcare workers.²⁶ Similarly, limited knowledge and inadequate practice were identified as key contributors to the underreporting of medication-related patient safety incidents among resident doctors in India.²⁵ These discrepancies may reflect differences in study populations, clinical settings, and reporting contexts, suggesting that the influence of knowledge and attitudes on reporting behavior varies across healthcare environments.

Interestingly, this study, gender was the only factor significantly associated with reporting practices. This finding is consistent with some previous studies that revealed gender differences in patient safety incident reporting.²³ However, other studies have found no significant association between gender and medical error reporting practices, such as a study among Jordanian nurses.²⁷ These inconsistent findings suggest that the role of gender in reporting behavior remains unclear. Some studies have proposed that differences in communication styles and professional roles contribute to variations in reporting practices.¹² Nevertheless, the observed association should be interpreted

cautiously because the statistical significance was marginal, the sample size was relatively limited, and multiple statistical comparisons were performed, which may increase the likelihood of type I error. Further studies are needed to confirm this finding.

The absence of associations between work experience, knowledge, and attitudes and reporting practices may also reflect the influence of contextual and organizational factors. Although participants generally demonstrated positive attitudes and varying levels of knowledge in this study, these individual attributes did not translate into consistent reporting behaviors. This suggests that external constraints override individual readiness to report. High workload and time constraints have been identified as major barriers in complex clinical environments, limiting opportunities for healthcare workers to engage in reporting activities during routine practice.^{11, 27} In addition, inadequate reporting systems and lack of feedback mechanisms may further discourage reporting behavior, as healthcare workers may perceive reporting as time-consuming and of limited practical value.⁵ Without visible outcomes or system-level responses, motivation to report may diminish over time. These findings highlight that improving reporting practices requires addressing structural and organizational barriers rather than relying solely on enhancing individual competencies.

From a practical perspective, the findings indicate that improving knowledge or attitudes is not sufficient to enhance reporting practices. Therefore, future quality improvement initiatives may consider strengthening the operational aspects of reporting systems. This includes simplifying reporting procedures, integrating user-friendly electronic reporting platforms, and ensuring efficient reporting within routine clinical workflows. In addition, regular training should focus on practical scenarios, such as identifying reportable events, applying severity classification, and accurately completing reporting forms. Moreover, organizational strategies are essential. Establishing clear feedback mechanisms, where healthcare workers receive timely and meaningful responses after submitting reports, may increase engagement and trust in reporting systems.²⁸ Furthermore, leadership support and a visible commitment to patient safety can reinforce a transparent culture. Creating a psychologically safe environment in which staff feel protected from blame and punitive consequences is particularly important to encourage open reporting.² Finally, providing emotional and professional support to healthcare workers involved in adverse events may help mitigate the impact of the “second victim” phenomenon and promote sustained reporting behaviors.⁸

This study has several strengths, including a comprehensive assessment of KAP and the use of correlation and association analyses. However, several limitations should be acknowledged. The cross-sectional design limits causal inference and does not allow the determination of the temporal relationships among knowledge, attitudes, and reporting practices. Furthermore, the study was conducted in a single hospital and employed convenience sampling, limiting the sample representativeness and the generalizability of the findings. Additionally, self-reported data may be subject to reporting bias, as noted in previous methodological discussions.¹⁰ Reporting practices were assessed only among healthcare workers with prior experience of patient safety incidents because the practice items evaluated behaviors performed during the reporting process. Consequently, the findings regarding reporting practices may not be generalizable to all healthcare workers. The study did not distinguish between participants who had never encountered a reportable patient safety incident and those who did not personally submit a report because reporting was undertaken by another team member.

Conclusions

This study revealed a clear discrepancy of KAP regarding patient safety incident reporting among healthcare workers in a tertiary hospital in Vietnam. Although attitudes toward reporting were generally positive, knowledge remained insufficient; reporting practices were suboptimal. Notably, among healthcare workers with prior patient safety incident reporting experience, knowledge and attitudes were not significantly associated with reporting practices, suggesting that individual awareness alone is not sufficient to influence reporting behavior. Instead, contextual and system-level factors are likely to play a more important role. These findings highlight the need for comprehensive strategies to improve patient safety incident reporting. Interventions should move beyond awareness raising and focus on strengthening practical training, clarifying reporting procedures, and improving system usability. In addition, fostering a supportive, nonpunitive reporting culture and ensuring timely feedback may enhance reporting behaviors. Future research should further explore the organizational and environmental factors that influence reporting practices to inform targeted patient safety interventions.

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Additional Information

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Ethics Approval: The institutional scientific and ethics committee of the Da Nang C Hospital approved the study (No. 335/QD-BVC on 25 March 2024). All procedures were conducted in accordance with the ethical standards of the institutional research committee. Participation was voluntary, and all participants provided informed consent prior to data collection. Participants were assured of the confidentiality and anonymity of their responses, and no identifiable personal information was collected.

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