Implementing Just Culture for Patient Safety Incident Management in Mental Hospitals: An HRM Perspective

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Abstract
This study explores nurses' experiences following patient safety incidents and the implementation of a just culture in mental hospitals from a human resource management perspective. A qualitative phenomenological approach was used through in-depth interviews with 12 nurses and thematic analysis. The findings show that patient safety incidents cause anxiety, guilt, fear, and emotional distress while encouraging professional reflection and increased vigilance. Just culture was perceived as a constructive and non-punitive approach that emphasizes balanced accountability between individual and system factors. Organizational support, workload management, workforce planning, and continuous patient safety training were identified as essential strategies for reducing post-incident impacts. The study concludes that integrating a just culture with human resource management practices supports organizational learning and sustainable patient safety improvement. However, the qualitative design, limited number of participants, and single-hospital setting may restrict generalizability. This study contributes to the understanding of post-incident nursing management through organizational support and learning-oriented approaches.

Keywords: *Human Resource Management, Just Culture, Nurse, Patient Safety Incident, Phenomenology*

1. INTRODUCTION

Patient safety incidents remain a strategic issue in healthcare systems because they directly affect service quality, patient well-being, organizational reputation and institutional sustainability. Global healthcare organizations emphasize that patient safety is a major priority in healthcare reform and requires an integrated and systemic approach. Modern patient safety strategies highlight the importance of establishing a safety culture that promotes incident reporting, organizational learning, and continuous quality improvement (Subbe et al. 2023). National and international reports also indicate that patient safety incidents continue to occur frequently and require stronger reporting systems and organizational learning mechanisms (Dhamanti, Rachman, Sholikhah, & Tjahjono, 2025). These conditions demonstrate that patient safety incidents can no longer be viewed merely as individual failures but rather as organizational responsibilities that must be managed systematically.

Healthcare workers involved in patient safety incidents frequently experience significant psychological effects. Previous studies have shown that involvement in adverse events may generate psychological and psychosomatic symptoms, such as anxiety, guilt, emotional distress, sleep disorders, and prolonged stress (Busch et al., 2020b). Further meta-analytic studies have identified that coping strategies among healthcare workers after incidents are strongly influenced by organizational support and workplace environments (Busch et al., 2020a). Recent qualitative findings describe the second victim experience as a dynamic process shaped by organizational culture, leadership responses, and support systems (Brunelli, Seisdedos, & Martinez, 2024). Similar findings have been reported among nurses in several countries, where emotional distress and the need for professional support emerged as dominant themes following patient safety incidents (Choi et al., 2020; Damanik, Prasetyo, Alie, & Oktaria, 2025; Huang, Sun, Chen, Li, & Wang, 2022). These findings confirm that healthcare workers are directly affected by patient safety incidents and require adequate organizational intervention.

The psychological impact experienced after incidents does not only influences individual well-being and affects broader human resource management dimensions within healthcare organizations. Research has demonstrated that post-incident distress is associated with increased turnover intention, absenteeism, and decreased work productivity (Burlison et al., 2021). Other studies have reported that patient safety incidents negatively influence nurses' quality of work life and professional confidence (Kim & Lee, 2023). Furthermore, inadequate organizational support may intensify emotional burdens and discourage incident-reporting behaviors (Jukarainen et al., 2026). The

phenomenon of third victims among patient safety professionals also illustrates that the consequences of incidents may extend to the managerial and organizational levels (Holden & Card, 2019). Therefore, the management of patient safety incidents requires a comprehensive human resource management approach that emphasizes organizational support and workforce well-being.

A just culture has become a strategic approach to developing sustainable patient safety systems in healthcare organizations. Just culture emphasizes balanced accountability between individual actions and systemic factors while creating a psychologically safe environment for incident reporting without disproportionate punishment (Ongko & Chalidyanto, 2023). Empirical evidence demonstrates that implementing a just culture positively affects nurses' attitudes and behaviors toward incident reporting (Han et al., 2024). Previous studies also found that strengthening patient safety culture improves organizational learning capacity and supports injury prevention efforts (Domer et al., 2021; Mistri, Badge, & Shahu, 2023). International policy frameworks emphasize that supporting healthcare workers after incidents is integral to patient safety strategies. Thus, a just culture should not be understood merely as a non-blaming culture but rather as an organizational governance framework that supports accountability, learning, and staff well-being.

Mental hospitals possess unique risk characteristics, including patient aggressiveness, self-harm potential, and the need for intensive supervision, which increase the complexity of healthcare services in these facilities. These conditions elevate the possibility of patient safety incidents while simultaneously increasing the psychological pressure on nurses who provide continuous patient care. Although various patient safety guidelines have been established (Lonatrista & Tj, 2025), empirical studies on the implementation of a just culture in psychiatric hospitals, particularly from a human resource management perspective, remain limited. This research gap highlights the importance of studies integrating nurses' experiences with organizational policies and workforce management strategies.

This study aimed to explore nurses' experiences following patient safety incidents in mental hospitals and examine how just culture and human resource management practices support post-incident management and organizational learning in the nursing field. A qualitative phenomenological approach was employed to gain an in-depth understanding of the participants' lived experiences (Creswell & Creswell, 2017; Praveena & Sasikumar, 2021). Therefore, this study is expected to contribute theoretically and practically to the development of patient safety policies and human resource management practices in mental hospitals. The integration of just culture principles with supportive managerial approaches is expected to create safer, fairer, and more sustainable healthcare systems.

2. LITERATURE REVIEW

2.1 Patient Safety and Health Care Incidents

Patient safety incidents are unexpected events that occur during healthcare processes and may result in or potentially cause harm to patients. Patient safety is a fundamental indicator of healthcare quality and an essential component of an effective health system. Through the Global Patient Safety Action Plan 2021-2030, Lonatrista and Tj (2025) further highlighted the importance of strengthening reporting systems, organizational learning, and safety culture to minimize adverse events in healthcare settings. The concept of a patient safety culture also emphasizes shared organizational values, openness, and continuous learning to prevent patient harm. The Agency for Healthcare Research and Quality explain that the patient safety culture reflects how healthcare organizations prioritize safety through communication, teamwork, leadership commitment, and incident reporting systems. Similarly, Guerra-Paiva et al. (2023) reported that patient safety incidents significantly affect healthcare costs, organizational sustainability and service quality worldwide.

National reports in Indonesia also indicate that patient safety incident reporting systems still face challenges related to reporting consistency, transparency, and utilization of incident data for system improvement (Dhamanti et al., 2025). Incident reporting systems should focus on organizational learning rather than individual blame. Previous studies have demonstrated that patient safety incidents affect not only patients but also generate psychological consequences for healthcare workers. Van Gerven et al. (2016) found that healthcare professionals involved in incidents

frequently experience emotional distress and recovery difficulties after adverse events. Similarly, Coughlan, Powell, and Higgins (2017) described the second victim phenomenon as a condition in which healthcare workers experience emotional trauma following patient safety incidents. These findings confirm that patient safety incidents are multidimensional phenomena involving clinical, psychological, and organizational aspects that require systemic management.

2.2 Psychological and Professional Impact of Health Workers After the Incident

Healthcare workers involved in patient safety incidents frequently experience emotional and psychological burdens. Busch et al. (2020b) conducted a systematic review and meta-analysis and identified psychological symptoms, including anxiety, stress, guilt, sleep disorders, and psychosomatic complaints, among healthcare workers after adverse events. Further studies have revealed that coping strategies following incidents are strongly influenced by workplace support systems and organizational culture (Busch et al., 2020a). The second-victim phenomenon has gained increasing attention in patient safety research. Brunelli et al. (2024) described second victim experiences as dynamic processes influenced by organizational environments, leadership responses, and support mechanisms. Similar findings have been reported among nurses in Korea and China, where emotional distress, fear of blame, and the need for organizational support emerged after patient safety incidents (Choi et al., 2020; Huang et al., 2022).

Research has also demonstrated that psychological distress following incidents affects professional performance and workforce stability. Burlison et al. (2021) found significant relationships between second victim distress, turnover intentions, absenteeism, and reduced productivity. Similarly, Kim and Lee (2023) reported that patient safety incidents negatively affect nurses' quality of work-related lives and professional confidence. Moreover, Jukarainen et al. (2026) emphasized that insufficient organizational support may worsen practitioners' psychological well-being and discourage future reporting of incidents. The impact of incidents may also extend to patient safety managers and professionals, who are described as third victims in healthcare systems (Holden & Card, 2019). These findings indicate that patient safety incidents influence not only clinical performance but also healthcare workers' psychological well-being, organizational commitment and professional sustainability.

2.3 Safety Culture and Fair Culture in Health Care Organizations

Patient safety is considered a fundamental component of effective healthcare governance. Subbe et al. (2023) emphasized that healthcare organizations should establish environments that support openness, transparency, accountability, and organizational learning, without excessive fear of punishment. A just culture is an important approach to patient safety because it balances individual accountability with organizational responsibility. Ongko and Chalidyanto (2023) explained that leadership support, communication quality, and staff empowerment significantly influence the development of a just culture in healthcare organizations.

Empirical evidence also demonstrates that a just culture positively affects healthcare workers' reporting behavior. Han et al. (2024) found that nurses who perceived stronger just culture environments showed more positive attitudes toward patient safety and incident reporting. Likewise, Krouss, Alshaikh, Croft, and Morgan (2019) emphasized that supportive reporting systems and educational interventions improve healthcare workers' willingness to participate in organizational learning processes.

In the Indonesian healthcare context, Kartikasari and Samirah (2024) reported that the perceptions of patient safety culture among doctors, nurses, and pharmacists are closely related to open communication and evaluation of work procedures. Furthermore, Mistri et al. (2023) and Domer et al. (2021) highlighted that strengthening the patient safety culture requires continuous managerial commitment, organizational learning systems, and staff engagement. Recent organizational case studies have also demonstrated that transforming safety culture from blame-oriented systems to learning-oriented systems contributes to improved staff trust and patient safety outcomes (Boutwell, Cornet, & Mannering, 2024). Therefore, a just culture should be understood as

an organizational governance framework that supports accountability, learning, psychological safety, and continuous improvement.

2.4 Human Resource Management Perspective in Patient Safety

Human Resource Management (HRM) plays a strategic role in strengthening patient safety systems through workforce planning, staff development, supervision, performance evaluation, and employee well-being programs. Kim and Lee (2023) showed that patient safety incidents significantly influence nurses' work-related quality of life, emphasizing the need for responsive organizational policies. Support systems for healthcare workers following incidents are essential components of organizational governance. Rika and Tj (2026) recommended developing structured staff support systems after patient safety incidents as part of sustainable patient safety strategies. Similarly, Zhang, Yang, Liang, Feng, and Zhang (2024) found that leadership support and reflective organizational environments contribute to professional growth among nurses following patient safety incidents.

Training and incident reporting systems are equally important in healthcare workforce management. Krouss et al. (2019) emphasized that continuous patient safety training and clear reporting procedures increase healthcare workers' participation in organizational learning and safety improvement initiatives. From a policy perspective, the importance of integrating incident reporting systems with workforce development strategies was stressed. These approaches are consistent with Lonatrista and Tj (2025), who identified organizational support and workforce engagement as key pillars of sustainable patient safety systems. Therefore, patient safety incident management requires systematic human resource management policies that prioritize workforce well-being, organizational learning, and a supportive workplace culture.

2.5 Theoretical Frameworks

The literature demonstrates that patient safety incidents generate multidimensional consequences that affect patients, healthcare workers, and healthcare organizations. The psychological and professional impacts experienced by healthcare workers after incidents highlight the importance of organizational support systems and sustainable workforce management practices. The implementation of a just culture, combined with effective human resource management strategies, is considered a critical approach for strengthening patient safety systems, improving incident reporting behaviors, supporting healthcare workers' well-being, and promoting organizational learning. This literature review provides a conceptual foundation for exploring nurses' experiences regarding patient safety incidents and analyzing the implications of just culture and human resource management practices in mental hospital settings.

Tabel 1. Conceptual framework of the study

Main Concept	Key Findings	Implications
Patient Safety Incidents	Incidents affect the quality of care, organizations, and patients.	Reporting and learning systems are required.
Psychological Impact on Nurses	Nurses may experience guilt, fear, stress, and a reduction in their confidence.	Emotional support is needed for the staff.
Just Culture	It promotes accountability, openness, and non-punitive responses.	It encourages trust and transparent reporting.
HRM Perspective	It covers training, supervision, workload, and post-incident support.	Strengthens the safety culture and staff well-being.

Table 1 summarizes the main concepts related to patient safety. This shows that a just culture and effective human resource management are essential to support nurses, improve incident reporting, reduce psychological impacts, and strengthen organizational learning in healthcare settings. This study proposes that patient safety incidents influence nurses' psychological and

professional experiences, while the implementation of a just culture supported by human resource management practices may reduce negative impacts, strengthen organizational learning, and improve patient safety in mental hospitals.

3. METHODOLOGY

3.1 Research Design

This study employed a qualitative approach with a descriptive phenomenological design. This approach was selected because the research aimed to explore nurses' experiences regarding patient safety incidents, as well as the meaning of just culture and human resource management practices in mental hospitals. Creswell and Creswell (2017) explained that phenomenological research is intended to explore and understand participants lived experiences related to a particular phenomenon in depth and systematically. In addition, qualitative approaches are considered appropriate for understanding subjective experiences and their meanings within organizational contexts (Sugiyono, 2016).

The data analysis process referred to the descriptive phenomenological stages of the Colaizzi method, as explained by Praveena and Sasikumar (2021), including identifying significant statements, formulating meanings, organizing themes, developing comprehensive descriptions, and validating findings with participants. Interpretative phenomenological principles were also considered to support the exploration of participants' experiences and meanings in healthcare settings (Charlick, Pincombe, McKellar, & Fielder, 2016).

3.2 Scope and Research Objects

This study examines the experiences of nursing staff concerning patient safety incidents and their implications for human resource management practices and the implementation of a just culture in psychiatric hospital organizations. This study focuses on nurses' emotional and professional responses following involvement in patient safety incidents, health workers' understanding of just culture implementation in healthcare organizations, and the role of human resource management functions, such as training, performance evaluation, workload management, and post-incident psychological support. Additionally, it explores the relationship between incident reporting systems and organizational learning, as emphasized by Lonatrista and Tj (2025) and the national patient safety policies (Dhamanti et al., 2025). This study did not discuss the medical clinical aspects in depth or perform a quantitative analysis of incident rates. The main focus is on the meaning of participants' experiences and the organizational implications for workforce management.

3.3 Population and Sample

3.3.1 Population

The research population included all nursing staff and human resource managers at the West Java Provincial Mental Hospital who were involved in or responsible for patient safety incidents. This population includes executive nurses in inpatient units and officials or staff who handle human resource management functions such as training, performance evaluation, and workforce development. The determination of this population is based on the characteristics of the hospital organization as a health service system that has an incident reporting and learning mechanism, as recommended by Bhimasta, Surya, and Pramudita (2025) and national patient safety policies (Dhamanti et al., 2025).

3.3.2 Sample

This study used a purposive sampling technique, namely, the deliberate selection of participants based on certain criteria relevant to the research objectives. This approach is in accordance with the character of qualitative research, which focuses on the depth of information, not statistical representation (Creswell & Creswell, 2017). The sample consisted of 12 participants, including nine executive nurses who had been involved in patient safety incidents and three human resource managers responsible for training policies, performance evaluation, and staff support. The inclusion criteria for nurses were prior experience with patient safety incidents, at least one year of work experience, and willingness to participate in the in-depth interviews. HR managers were

included if they were involved in the decision-making or implementation of workforce management policies.

The number of participants was determined based on the principle of data saturation, which refers to the point at which additional interviews no longer generated new themes, meanings, or relevant information related to nurses' experiences, the just culture, and human resource management practices. Saturation was achieved after repeated patterns, and consistent responses emerged across participants. Therefore, 12 participants were considered sufficient to provide rich and in-depth information consistent with the objectives of phenomenological research (Creswell & Creswell, 2017).

3.4 Data Types and Sources

3.4.1 Data Types

This study used qualitative data that were descriptive and exploratory in nature. Qualitative data were obtained in the form of participants' narratives, experiences, perceptions, and meanings regarding patient safety incidents, fair culture, and human resource management practices. The data collected included nurses' emotional and professional responses following their involvement in patient safety incidents, participants' perceptions of incident reporting and organizational learning systems, their understanding of just culture implementation within the organization, and the forms of organizational support and post-incident human resource management policies provided to them. These data are consistent with the phenomenological approach, which seeks to explore and understand the meaning of participants' lived experiences in depth (Creswell & Creswell, 2017).

3.4.2 Data Source

The research data sources consisted of primary and secondary data. Primary data were obtained through semi-structured in-depth interviews with 12 participants, comprising nine executive nurses who had been involved in patient safety incidents, and three human resource managers responsible for workforce management policies. These interviews served as the main source for identifying themes and interpreting the participants' experiences related to patient safety incidents and their implications for organizational practice. Secondary data were obtained from relevant internal hospital documents, including patient safety policies, incident-reporting guidelines, and health worker training programs. In addition, this study referred to policy documents and scientific literature related to patient safety and workforce management, national patient safety reports by Dhamanti et al. (2025), and incident reporting systems. Secondary data were used to strengthen the research context and support the interpretation of the interview findings.

3.5 Data Collection Techniques

This research uses the main data collection technique in the form of in-depth interviews with a semi-structured approach to collect data. This technique was chosen to gain a comprehensive understanding of nurses' experiences regarding patient safety incidents and human resource managers' perspectives on organizational policies.

3.5.1 In-depth Interview

Interviews were conducted face-to-face with 12 resource persons, consisting of nine executive nurses and three human resource managers. Each interview session lasted ±45–60 minutes. The interview process was recorded with the participants' consent and transcribed verbatim for analysis. The interview guide was prepared based on a literature review regarding the psychological impact on health workers (Busch et al. (2020b); Brunelli et al. (2024), fair culture and incident reporting (Han et al. (2024); Ongko & Chalidyanto (2023), and patient safety learning systems (Dhamanti et al., 2025). The guide contained open-ended questions that allowed participants to explain their experiences, feelings, and perceptions of organizational support and human resource management policies. The semi-structured approach provides flexibility for researchers to explore information in greater depth according to participant responses without leaving the focus of the research.

3.5.2 Documentation Study

In addition to interviews, research also utilizes documentation studies as a supporting technique. The documents reviewed included patient safety policies, incident reporting guidelines, health worker training programs, and hospital human resource management policies. Documentation was used to understand the organizational context and confirm the information obtained through interviews. The use of documents also supports the principle of source triangulation to increase the credibility of findings.

3.5.3 Data Recording and Management

All the interview data were transcribed in full. The researcher conducted repeated readings to ensure the accuracy of the transcripts before entering the analysis stage. The recording process was carried out systematically to facilitate the identification of significant statements according to the phenomenological analysis stages described by Praveena and Sasikumar (2021).

3.6 Operational Definition of Variables

This study uses a qualitative phenomenological approach to define the focus of the study operationally based on a conceptual framework and relevant empirical findings.

3.6.1 Patient Safety Incident

A patient safety incident is an unexpected event that occurs during the health service process and has the potential to cause injury to the patient, either due to actions taken or not. This concept emphasizes the importance of reporting systems, organizational learning, and continuous improvement within the patient safety framework. Incidents are understood as part of complex healthcare system dynamics and require structured organizational responses (Subbe et al., 2023).

3.6.2 Second Victim Experience

The second-victim experience is the emotional, psychological, and professional response experienced by nurses after being involved in a patient safety incident. These responses can range from guilt, anxiety, stress, sleep disturbances, and decreased concentration to professional reflection on work practices (Busch et al., 2020b; Huang et al., 2022). Research shows that this experience is dynamic and influenced by organizational support and the work environment (Brunelli et al., 2024). This impact is also related to work consequences, such as intentions to leave work and absenteeism (Burlison et al., 2021).

3.6.3 Just Culture

A just culture is an organizational approach to handling patient safety incidents that balances individual accountability and system responsibility and encourages reporting without the fear of disproportionate punishment. A fair culture emphasizes organizational learning, transparency, and support for healthcare workers involved in incidents (Han et al., 2024; Ongko & Chalidyanto, 2023). The implementation of a just culture has been proven to improve attitudes and behaviors in reporting incidents and strengthen commitment to patient safety (Han et al., 2024).

3.6.4 Human Resource Management Perfective

The human resource management perspective is a health workforce management approach that includes workforce planning, training and development, performance assessment, welfare support, and occupational health and safety policies as part of an organization's strategy. In the context of patient safety, human resource management plays a role in creating a supportive work environment, facilitating post-incident learning, and minimizing the psychological impact on the staff (Burlison et al., 2021; Kim & Lee, 2023). This approach is in line with the patient safety systems framework, which places organizational support as a key component in building a safety culture (Subbe et al., 2023).

3.7 Data Validity

This research applies qualitative data validity criteria, which include credibility, dependability, confirmability, and transferability, as explained by Creswell and Creswell (2017). The application of these criteria aims to ensure that research findings have an adequate level of trustworthiness, consistency, and contextual relevance.

3.7.1 Credibility

Credibility is achieved using several strategies. First, the researchers carried out source triangulation by involving two groups of participants, namely nurse practitioners and human resource managers. These different perspectives allow for the cross-verification of the information obtained. Second, the researcher applied the member checking technique, namely confirming the summary of findings with several participants to ensure conformity between the researcher's interpretation and the experience conveyed. Third, the use of documentation studies as supporting data helped strengthen the organizational context and validate information from interviews.

3.7.2 Dependability

Dependability was maintained through systematic documentation of the research process, starting from the planning stage, data collection, and analysis, to report preparation. The analysis process follows the descriptive phenomenology steps of the Colaizzi method, as described by Praveena and Sasikumar (2021), so that the stages of analysis can be traced clearly. Field notes, interview transcripts, and the coding process were kept as part of the research audit trail.

3.7.3 Confirmability

Confirmability was achieved by maintaining objectivity during the analysis process. The researcher separated data interpretation from personal assumptions through repeated reading of transcripts and formulating meaning based on participants' significant statements. The analysis process and results of theme grouping were documented transparently to enable review.

3.7.4 Transferability

Transferability was strengthened by presenting a detailed description of the research context, including hospital characteristics, participant characteristics, and organizational situations related to patient safety incidents. Presenting this context allows readers to assess the applicability of the findings to situations in other organizations with similar characteristics.

3.8 Data Analysis Techniques

This study used qualitative data analysis techniques with a descriptive phenomenological approach. The analysis process aimed to identify the meaning of participants' experiences regarding patient safety incidents, perceptions of a fair culture, and implications for human resource management practices. Data analysis refers to the steps of the Colaizzi method as explained by (Praveena & Sasikumar, 2021), which allows researchers to systematically obtain essential descriptions of participants' experiences. Data analysis was conducted in the following stages:

3.8.1 Read the Transcript Thoroughly

The researcher read the entire interview transcript several times to gain a thorough understanding of the context of the participants' experiences. This stage aimed to capture a general picture of the phenomenon before coding.

3.8.2 Identify Significant Statements

Researchers marked statements that were relevant to the research focus, namely, post-incident experiences, emotional and professional responses, the meaning of a fair culture, and organizational support. Significant statements were selected based on their relevance to the research objectives.

3.8.3 Formulation of Meaning

Each significant statement was analyzed to formulate the meaning contained therein. This process was carried out reflectively while maintaining the original context of the participants' experiences.

3.8.4 Grouping Meanings into Themes

The meanings that were formulated were grouped based on similarities in pattern and substance and then arranged into main categories and themes. This process produces a thematic structure that comprehensively describes the participants' experiences.

3.8.5 Preparing a Comprehensive Description

Researchers created narrative descriptions that explained the essence of participants' experiences regarding patient safety incidents and their implications for organizational practices.

3.8.6 Validation for Participants (Member Checking)

The results of the thematic description were confirmed by several participants to ensure conformity between the researcher's interpretation and the experiences conveyed.

4. RESULT AND DISCUSSION

4.1 Research Results

The research results were obtained through in-depth interviews with 12 sources, consisting of 9 executive nurses who had been involved in patient safety incidents and 3 human resource managers at the West Java Provincial Mental Hospital. Data analysis used Colaizzi's descriptive phenomenology method as explained in phenomenological research (Creswell & Creswell, 2017; Praveena & Sasikumar, 2021). The analysis process produced four main themes that represent nurses' experiences and managerial perspectives on managing patient safety incidents.

Table 2. Themes and subthemes of research results

No	Main Theme	Subtheme
1	Emotional responses after the incident	Shock and fear, anxiety about consequences, guilt, and emotional distress
2	Impact on professional performance	Decreased concentration, sleep disturbance, decreased self-confidence, and increased alertness
3	The meaning of a just culture	No blaming of individuals, focus on system factors, openness of reporting, and leadership support
4	The role of human resource management	Patient safety training, evaluation of work procedures, workload management, and psychological support

Based on Table 2, the research findings can be explained using four main themes. First, all nurses involved in the incident reported emotional responses during the initial phase. These responses included shock, fear of professional consequences, and feelings of guilt regarding the patient's condition. Several participants also reported emotional distress that persisted for several days after the incidents. One participant stated, "*At that time, I felt panic and shock after the incident*" (N1). Another participant explained, "*I felt anxious, could not sleep well, and experienced fear after the incident*" (N3). These emotional responses demonstrate that patient safety incidents are interpreted not only as clinical events but also as personal experiences that impact nurses' psychological well-being. HR managers acknowledged that this emotional dimension is often not formally reflected in the incident reports.

Second, in the initial post-incident phase, some nurses experienced impaired concentration, doubts in clinical decision-making, and decreased self-confidence due to the trauma. Some participants also reported sleep disturbances that affected their readiness to work during the next shift. However, some nurses stated that the incident experience increased their vigilance in performing care procedures. One participant reported, "*After the incident, I became more careful and*

more aware of patients with certain risks" (N1). Another participant stated, "*The incident became a lesson for me to be more thorough and more careful in providing care*" (N5). These findings suggest two possible professional responses: a temporary decline in performance and a long-term increase in caution. HR managers emphasized that changes in work behavior after an incident are often not systematically documented despite their implications for service quality.

Third, most interviewees defined a culture of justice as an approach that does not directly blame individuals but instead examines systemic factors, such as workload, team communication, and clarity of procedures. Nurses stated that openness in reporting incidents was greatly influenced by the attitude of unit leaders. When leaders are supportive and focused on system evaluation, nurses feel more psychologically safe when reporting incidents. One participant explained, "*I was afraid to report the incident because I worried about being blamed or punished*" (N4). Another participant stated, "*Supportive leaders made me feel safer to explain what really happened*" (N6). Human resource managers stated that the implementation of a culture of justice is still being strengthened, particularly in terms of consistent communication and policy integration.

Fourth, the participants emphasized the importance of ongoing patient safety training and constructive supervision. Furthermore, workload management and informal emotional support from direct supervisors were considered helpful in the recovery process for nurses after an incident. One participant stated, "*Support from supervisors helped me recover emotionally after the incident*" (N2). Another participant explained, "*Regular training made us more prepared to prevent similar incidents*" (N7). Human resource managers stated that formal psychological support was not yet fully structured despite the recognized need for it. This indicates the need to strengthen HR policies for managing patient safety incidents.

4.2 Discussion

The findings regarding nurses' emotional responses support the second victim phenomenon, which explains that healthcare workers experience significant psychological impacts after involvement in patient safety incidents. Previous studies have reported that anxiety, guilt, stress, and emotional distress are common responses following adverse events (Busch et al., 2020b; Coughlan et al., 2017). Similar findings have been identified among nurses in several healthcare settings, where organizational support influenced emotional recovery processes (Choi et al., 2020; Huang et al., 2022). Recent studies have further described second victim experiences as dynamic processes shaped by organizational environments, leadership, and support systems (Brunelli et al., 2024). Van Gerven et al. (2016) found that healthcare workers often experience prolonged emotional recovery following incidents. The findings of this study are therefore consistent with previous evidence indicating that patient safety incidents psychologically and professionally affect healthcare workers.

The participants' interpretation of just culture aligns with the literature, emphasizing balanced accountability between individuals and healthcare systems. Ongko and Chalidyanto (2023) explained that leadership, communication quality, and staff empowerment are important determinants of developing a just culture within healthcare organizations. Similarly, Han et al. (2024) demonstrated that stronger perceptions of just culture positively influenced nurses' attitudes and behaviors regarding incident reporting. The findings are consistent with broader patient safety frameworks emphasizing openness, learning systems, and non-punitive organizational environments. Studies on patient safety culture emphasize that transforming blame-oriented cultures into learning-oriented systems contributes to improved organizational trust and safety outcomes (Boutwell et al., 2024; Mistri et al., 2023).

From a human resource management perspective, the findings demonstrate that integrating workforce support systems, patient safety training, supervision, workload management, and psychological support is essential for strengthening sustainable patient safety systems. Domer et al. (2021) emphasized that organizational learning and patient safety capacity building are important strategies in reducing patient harm and improving healthcare quality. The importance of organizational support following patient safety incidents is also supported by Rika and Tj (2026), who recommend structured staff support systems as part of responsible healthcare governance.

Krouss et al. (2019) similarly emphasized that training and clear reporting systems improve healthcare workers' participation in organizational learning processes.

In addition, Zhang et al. (2024) found that supportive leadership and reflective work environments may encourage professional growth after patient safety incidents. These findings strengthen the argument that integrating just culture principles with human resource management practices can reduce psychological burdens, maintain workforce stability, and improve organizational learning in mental hospital settings. Overall, the results of this study indicate that implementing a just culture supported by systematic human resource management practices contributes to minimizing psychological impacts on nurses, maintaining professional performance stability, and promoting continuous organizational learning in efforts to improve patient safety.

5. CONCLUSIONS

5.1 Conclusion

This study shows that patient safety incidents affect nurses not only professionally but also psychologically, causing anxiety, fear, guilt, and emotional distress among them. The findings also demonstrate that a just culture plays an important role in creating a supportive environment that encourages openness, learning, and balanced accountability. From a human resource management perspective, organizational support, workload management, supervision, and continuous patient safety training are essential for reducing the negative impact of incidents and strengthening patient safety practices.

This study highlights the importance of integrating just culture principles with human resource management strategies to support nurses after patient safety incidents and improve organizational learning in mental hospitals. Hospitals should establish structured psychological support systems, strengthen non-punitive reporting systems, and provide regular patient safety training and supportive supervision to improve staff well-being and patient safety.

However, this study was limited to a qualitative design with a small number of participants from a single hospital setting, which may limit the generalizability of its findings. Future studies should involve broader healthcare settings and larger participant groups to obtain more comprehensive insights into post-incident management and just culture implementation. This study contributes to the development of learning-oriented patient safety management by emphasizing the integration of a just culture and supportive human resource management practices in mental hospitals.

5.2 Research Limitations

This study had several limitations. First, the use of a qualitative phenomenological approach with a relatively small number of participants (12 individuals) limits the generalizability of the findings to the broader population. Second, the study was conducted in a single psychiatric hospital, which may not fully represent other healthcare organizations. Third, the data were based on participants' subjective experiences obtained through interviews, which may be subject to perception bias and recall bias. In addition, this study did not employ quantitative measures to assess psychological impact levels or patient safety outcomes, thus limiting the ability to explain the relationships between variables in a more measurable way.

5.3 Suggestions and Directions for Future Research

Future research is recommended to expand the scope by involving multiple hospitals or different types of healthcare institutions to enhance the generalizability of the findings. Quantitative or mixed-method approaches can also be applied to measure the impact of patient safety incidents and the effectiveness of just culture implementation more objectively. Further studies should focus on developing structured psychological support models for healthcare workers as second victims, including organizational interventions and relevant policies. Future research should examine the role of leadership styles, organizational climate, and communication systems in strengthening just culture and improving patient safety outcomes. Longitudinal research designs are also suggested to better

understand the long-term impact of patient safety incidents on healthcare workers and organizational performance.

AUTHOR CONTRIBUTION

DNA was responsible for developing the research ideas and conceptual framework, designing the research methodology, conducting data collection and analysis, and preparing the initial draft of the manuscript. EH contributed to validating the research instruments and data analysis results, provided technical guidance and supervision throughout the research process, and reviewed and refined the manuscript. G provided theoretical and practical insights, assisted in ensuring that the research findings met academic standards, and participated in revising the manuscript based on the reviewers' comments and suggestions.

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