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Legal liability of nurses in adverse events: A normative-empirical analysis of patient safety governance at RSUD dr. Soeroto Ngawi

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ABSTRACT

Adverse events pose a serious threat to patient safety in hospitals. Data from RSUD Dr. Soeroto Ngawi reveal fluctuations in medical incident cases over 2021–2024 (n=354), with procedural and medication errors dominating patient safety reports. A critical research gap persists regarding inconsistent SOP implementation and a blame culture that suppresses transparent incident reporting — gaps unaddressed through an integrated legal-empirical lens. This study aims to analyze forms of nursing negligence, construct a legal accountability framework, and identify barriers and resolution efforts at a regional public hospital. An empirical legal approach was employed, combining case-based and statutory analysis. Data were collected through in-depth interviews with eight key informants, observation, and document review, then analyzed using descriptive qualitative methods with legal triangulation. Results indicate that nursing negligence primarily occurs in patient identification and clinical communication during handover. Nurses' accountability is manifested through immediate clinical responses, IKP system reporting, and root-cause investigations under Law No. 17 of 2023 on Health. Accountability nonetheless remains hindered by psychological barriers and structural workload imbalances. The scientific contribution of this study is the Dual-Layer Accountability Model, which proportionately assigns legal liability between individual professional conduct and institutional systemic failures — a framework absent from prior Indonesian health law scholarship. It is recommended that hospital management adopt a non-punitive just culture, digitize incident reporting, and strengthen clinical risk management training to ensure legal certainty for nurses while advancing patient safety.

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INTRODUCTION

The guarantee of patient safety constitutes one of the most fundamental dimensions of modern healthcare systems and is expressly regulated within the national legal framework. Nurses, as frontline healthcare professionals with the highest intensity of patient interaction, bear a fundamental legal responsibility for ensuring that safety standards are consistently upheld across every level of care (Sukendar et al., 2021). This burden of responsibility is not merely ethical or professional in nature; it is also legally binding under Law Number 17 of 2023 on Health, which serves as the most recent regulatory milestone governing healthcare workforce management in Indonesia (Muhamad & Suminar, 2024). The increasingly dynamic complexity of clinical environments demands a synergy among professional competence, compliance with standard operating procedures, and comprehensive legal awareness as indispensable prerequisites for preventing patient safety incidents (Daming & Julwanda, 2022).

Adverse Events (AEs) remain a serious and persistent threat within both the global and national healthcare ecosystems. Empirical evidence indicates that the majority of medical incidents are not solely attributable to patients' clinical conditions; rather, they are more frequently triggered by systemic failures, procedural errors, and poor coordination among healthcare professionals (Siregar et al., 2023). The consequences of such incidents extend far beyond physical harm to patients, encompassing economic losses, psychological trauma, institutional reputational damage, and the potential for protracted legal disputes (Prayuti et al., 2024). The high prevalence of AEs across various healthcare facilities suggests that reactive clinical risk management is no longer adequate and must be replaced by a structured, preventive, and systems-based approach (Juliansen et al., 2023). This urgency necessitates a comprehensive evaluation of the effectiveness of patient safety programs at the institutional level.

Medical negligence in the context of nursing refers to a form of professional failure that occurs when a nurse fails to deliver care in accordance with the standard of reasonableness expected of a professional with equivalent qualifications under similar circumstances. Legally, such negligence may give rise to multidimensional liability, encompassing criminal, civil, and administrative-professional accountability (Alviana et al., 2024). Establishing the elements of negligence in medical litigation requires an in-depth analysis of the four classical legal components—duty, breach, causation, and damage—which frequently become the subject of substantive debate between legal and medical experts (Hartono & Indrawati, 2025). The spectrum of acts that may be categorized as negligence is broad, ranging from medication errors and failures in clinical observation to the administration of interventions without informed consent and improper delegation of medical tasks (Hertanto, 2025). Identifying the root causes of negligence is therefore a critical foundation for building a continuous and equitable system of improvement.

The phenomenon of AEs at RSUD Dr. Soeroto Ngawi, a regional general hospital, reflects an empirical reality that warrants special attention from the perspective of health law. As a regional referral facility, this hospital faces complex structural challenges, including high workloads, a suboptimal nurse-to-patient ratio, and resource constraints that frequently serve as contributing factors in medical incidents (Adiana et al., 2023). Variations in compliance with Standard Operating Procedures (SOPs) on the ground represent a critical indicator in assessing the legal risks faced by nursing staff, while simultaneously revealing the gap between formal regulation and the actual implementation of clinical services (Amir & Purnama, 2021). Human factors such as physical fatigue, ineffective interprofessional communication, and excessive workload pressure also contribute significantly to the increased probability of safety incidents (Syahputra & Suminar, 2023). These conditions call for an in-depth analysis of how regional healthcare institutions manage legal risk amid constrained capacity. RSUD Dr. Soeroto Ngawi is particularly significant as a research site because it typifies the structural conditions prevalent across Indonesia's regional public hospitals: high patient-to-nurse ratios, constrained operational budgets, and regulatory compliance demands that routinely exceed available institutional

resources. The adverse event patterns and accountability challenges documented at this hospital are therefore not exceptional but broadly representative, rendering the findings directly applicable to patient safety policy reform at the national level.

The gap between patient safety regulations and actual field practice creates a legal grey area that has the potential to generate conflicts detrimental to all parties involved. On one hand, nurses are expected to comply consistently with SOPs; on the other hand, a punitive incident-reporting culture drives a phenomenon of underreporting that obstructs the identification and improvement of systemic weaknesses (Mustofa & Aran, 2025). The inadequate legal protection afforded to healthcare workers who report incidents honestly further exacerbates this situation, as a system that should support transparency instead functions as an instrument of punishment (Dewangga et al., 2025). The failure to implement just culture principles in incident management at regional hospitals results in patient safety programs operating suboptimally, as systemic root causes are never properly identified or comprehensively addressed (Mardhika & Mufidi, 2023). Transparency and accountability are the two foundational pillars that must be strengthened in order to break the cycle of recurring errors in nursing practice.

Studies addressing this regulatory-practice gap have predominantly focused on tertiary or private hospitals, leaving regional public hospitals, which bear disproportionate patient loads with inferior resources, analytically underrepresented. Moreover, no prior Indonesian study has simultaneously examined the legal accountability dimensions of nursing negligence and the institutional systemic factors enabling such negligence through an integrated normative-empirical framework. This research addresses both gaps. Regarding the relative contribution of causal factors, the patient safety literature consistently estimates that systemic and institutional factors account for approximately 70% of adverse event occurrences, with individual professional factors contributing the remaining 30% (Adiana et al., 2023; Juliansen et al., 2023). This study's findings at RSUD Dr. Soeroto Ngawi are consistent with this distribution, with structural variables—nurse-to-patient ratios, reporting culture, and infrastructure adequacy—functioning as primary determinants, while individual factors such as knowledge deficits and fatigue operate as proximate mediating causes within a deficient institutional environment. Patient misidentification arises primarily from failure to implement mandatory dual-identifier verification during high-volume clinical periods and reliance on verbal rather than documented patient confirmation. Clinical communication failures during handover are caused principally by inconsistent application of structured communication protocols such as SBAR, incomplete clinical documentation, and time pressures that discourage thorough interprofessional information transfer between nursing shifts (Muhamad & Suminar, 2024; Mustofa & Aran, 2025).

The legal liability of nurses in nursing malpractice cases encompasses a wide and complex spectrum of dimensions. From a civil law perspective, the doctrine of vicarious liability enables hospitals, as institutions, to be held jointly accountable for acts of negligence committed by healthcare workers in the course of their employment (Rahardianto & Adriano, 2024). Criminal liability, meanwhile, may attach to individual nurses where sufficient evidence exists to establish the elements of a criminal offense as defined under applicable legislation (Daeng et al., 2023). The administrative-professional dimension adds a further layer of complexity, as the revocation of a practice license may have permanent career consequences for a nurse found to have violated professional standards (Widjaja, 2025). Achieving a fair balance between the protection of patients' rights and legal certainty for healthcare professionals represents the central challenge in developing an equitable health law system (Mahardika, 2026). A just and proportionate resolution of medical disputes can only be achieved when professional ethics serve as the primary foundation of every enforcement process (Sutedja et al., 2023).

This study offers scholarly novelty through an in-depth analysis of nurses' legal accountability by integrating a systems approach into the management of AEs in regional hospitals. The main focus of this research is to examine how nursing negligence—specifically

patient misidentification and clinical communication failures—generates legal liability within the healthcare delivery system at RSUD Dr. Soeroto Ngawi, and how both regulatory frameworks and institutional governance mechanisms can be strengthened to prevent the recurrence of adverse events. The research focuses on how formal regulations are implemented in clinical practice at RSUD Dr. Soeroto Ngawi with the aim of establishing legal certainty grounded in justice (Irianto, 2021). By examining the boundaries of legal liability between healthcare service providers and inherent medical risks, it is anticipated that a more proportionate model of legal protection for nursing professionals can be formulated (Riyanto et al., 2022). This study also integrates an analysis of judicial decisions and institutional policies as an empirical basis for developing actionable policy recommendations. The ultimate objective of this research is to construct a liability model that simultaneously supports improvements in healthcare service quality and guarantees the legal rights of all parties involved, thereby preventing the emergence of counterproductive defensive medicine practices on a systemic scale.

RESEARCH METHOD

This study is a sociological or empirical legal study that focuses on observing the effectiveness of the law in practice, specifically regarding the implementation of nurses' liability for medical negligence (Vitvitskiy et al., 2021). The approaches used are the case approach and the statute approach to analyze the alignment between patient safety regulations and the reality of clinical practice at RSUD Dr. Soeroto Ngawi. In this study, an Adverse Event (AE) is defined as any unintended harm occurring during healthcare delivery regardless of causation, whereas negligence constitutes a legally actionable subset of AEs in which harm is directly attributable to a nurse's failure to meet the standard of care expected of a reasonably competent professional under equivalent circumstances. Differentiation between the two categories was conducted through systematic application of the four classical negligence elements—duty, breach, causation, and damage—to each documented incident, ensuring that inherent medical risks and unforeseeable complications were excluded from the negligence classification (Riyanto et al., 2022; Zaini & Ade Mahmud, 2024). The case unit in the case approach refers to each individual Patient Safety Incident (IKP) report filed at RSUD Dr. Soeroto Ngawi during the study period of 2021–2024, with each report examined for its legal classification, causal structure, institutional response, and resolution outcome.

The research location was purposively selected at RSUD Dr. Soeroto Ngawi given the urgency of addressing Adverse Events in regional public hospitals characterized by high patient volumes and constrained healthcare staff ratios. The data for this study consist of primary data obtained through in-depth interviews with hospital management and the nursing committee, as well as secondary data sourced from primary legal materials such as Health Law No. 17 of 2023 and secondary legal materials in the form of relevant academic literature. Primary data were collected through in-depth interviews with eight purposively selected informants comprising: the Hospital Director; the Head of the Quality and Patient Safety Committee; three senior nurses with direct involvement in documented adverse events; the Head of the Nursing Committee; the Hospital Legal Affairs Officer; and one patient family representative. Inclusion criteria required a minimum of two years of relevant institutional experience and direct involvement in patient safety management. Data collection was further conducted through observation of patient safety incident reports and a review of literature relevant to the theory of legal liability. The research team was granted full access to anonymized IKP records for the period 2021–2024 under a formal data access agreement with hospital management, with patient-identifying information redacted prior to provision in compliance with applicable health data privacy regulations. The research instruments used included interview guidelines and a document checklist to identify variables related to factors causing negligence and barriers to incident reporting.

The collected data were processed through stages of data reduction, data presentation, and verification to ensure validity of information related to clinical risk management. Legal analysis was conducted through systematic comparison of documented nursing conduct against the standards prescribed in Articles 273, 277, 282, 283, 296, and 441 of Health Law No. 17 of 2023, supplemented by applicable nursing professional standards and relevant judicial decisions on nursing malpractice. Triangulation was performed across three data sources—interview transcripts, IKP incident records, and documentary legal materials—to validate legal categorizations and strengthen analytical credibility. Data analysis was conducted using qualitative descriptive methods with deductive reasoning to draw specific conclusions from general premises regarding nursing professional standards. Objectivity of interview data was ensured through three mechanisms: member-checking, whereby interview transcripts were returned to informants for accuracy verification; source triangulation across interview, observational, and documentary data; and peer debriefing with two independent legal scholars who reviewed preliminary analytical conclusions. Researcher reflexivity was maintained throughout by systematically documenting positional assumptions at each analytical stage. The entire analysis process was aimed at formulating a legal liability model that ensures justice for nurses and safety for patients within the healthcare system. This research was conducted in full accordance with research ethics principles, including voluntary informed participation, data confidentiality, and non-maleficence. All informants provided written informed consent prior to interviews, and the research protocol received institutional ethical clearance prior to data collection commencement.

RESULTS AND DISCUSSIONS

Research Result

The dynamics of adverse events at RSUD Dr. Soeroto Ngawi reveal significant fluctuations over the study period, a pattern that is theoretically attributable to variations in the effectiveness of clinical risk management systems and the stability of nursing workloads (Siregar et al., 2023). Based on reports from the Quality and Patient Safety Committee, procedural errors and medication errors consistently emerged as the most dominant categories of incidents recorded over a four-year period, reflecting systemic vulnerabilities that extend beyond individual human error (Prayuti et al., 2024). The peak incidence in 2022, which recorded 117 cases, represents a critical inflection point in the hospital's patient monitoring system and underscores the urgent need for structured, evidence-based intervention (Juliansen et al., 2023). Although a cumulative downward trend is observed through 2024, the persistence of incidents across all categories indicates that the underlying risk factors have yet to be fully and systematically addressed (Adiana et al., 2023). The distribution of adverse events by type and year is presented in the following table:

Table 1. Distribution of adverse events at RSUD Dr. Soeroto Ngawi (2021–2024)

Years	Medical Malpractice	Procedural Errors	Medication Errors	Nosocomial Infections	Total Cases
2021	8	58	30	0	96
2022	15	64	38	0	117
2023	9	57	16	0	82
2024	1	51	7	0	59
Total	33	230	91	0	354

It is important to clarify that not all 354 recorded cases constitute nursing negligence in the strict legal sense. Applying the four-element negligence framework (duty, breach, causation, damage) to each IKP report, this study estimates that approximately 124 cases (35.0%)—concentrated within the medical malpractice and medication error categories—contain sufficient evidence of individual professional breach attributable to nursing conduct. The remaining 230 cases (65.0%), predominantly procedural errors associated with systemic and environmental

conditions, reflect adverse events driven primarily by institutional failures rather than individual negligence. This distinction is analytically critical: conflating all AEs with nursing negligence would produce a disproportionate attribution of personal liability that neither reflects clinical reality nor satisfies the legal causation requirement under Health Law No. 17 of 2023.

The forms of nursing negligence identified in this study span both administrative and clinical domains, each carrying direct and significant implications for patient safety. The most prevalent administrative errors involved inaccurate verification of patient identity on blood request forms and incomplete or inconsistent medical record documentation (Amir & Purnama, 2021). Such documentation failures carry a substantial risk of precipitating transfusion errors or wrong-patient procedures—outcomes that can prove fatal when they circumvent multi-layered verification protocols (Alviana et al., 2024). At the clinical level, inadequate coordination between units during patient handover was found to create significant opportunities for critical clinical information to be distorted, delayed, or lost entirely (Syahputra & Suminar, 2023). This vulnerability is further compounded by the behavior of certain healthcare workers who bypass Standard Operating Procedures (SOPs) in the name of operational efficiency under conditions of high patient volume, thereby subordinating safety to expediency (Mustofa & Aran, 2025).

The resolution of adverse events at RSUD Dr. Soeroto Ngawi demonstrates a strong institutional orientation toward internal dispute resolution through mediation and amicable settlement mechanisms. Based on interview data and documentary analysis, all patient safety incidents recorded between 2021 and 2024 were successfully resolved through non-litigious channels, with no civil lawsuits or criminal charges filed against nursing staff or the institution (Mardhika & Mufidi, 2023). This outcome indicates that hospital management plays a proactive and decisive role in containing conflicts before they escalate to the formal legal domain (Rahardianto & Adriano, 2024). The non-litigation approach is widely recognized as more effective in preserving institutional reputation, maintaining therapeutic relationships, and providing timely remedies for patients who have suffered losses (Dewangga et al., 2025). Nonetheless, the sustained reliance on informal resolution mechanisms necessitates rigorous oversight to ensure that substantive justice is upheld and that professional accountability for nursing staff is not compromised or obscured in the process (Riyanto et al., 2022).

Nurses at RSUD Dr. Soeroto Ngawi demonstrate a degree of accountability through immediate clinical responses aimed at stabilizing the patient's condition upon detection of an incident. In compliance with institutional safety protocols, nurses are formally required to document and report all incidents through the Patient Safety Incident Reporting System (IKP) as a mechanism of both administrative and professional accountability (Hartono & Indrawati, 2025). Beyond curative interventions, nurses are also actively engaged in multidisciplinary investigation teams tasked with conducting Root Cause Analysis (RCA) and formulating evidence-based strategies to prevent recurrence (Sutedja et al., 2023). The implementation of structured communication standards using the SBAR method—Situation, Background, Assessment, and Recommendation—functions as a critical pillar of clinical accountability that all clinical staff are obligated to observe (Mu'ammar et al., 2024). This accountability framework thereby extends well beyond the immediate management of harm, encompassing a broader institutional commitment to continuous, systemic quality improvement (Ivan et al., 2025).

Based on the totality of empirical findings, this study generates the Dual-Layer Accountability Model as a new framework for assigning legal liability in nursing adverse events. This model operates on two simultaneous analytical dimensions: the Individual Layer, which evaluates whether a nurse's specific conduct deviated from professional standards and directly caused patient harm; and the Institutional Layer, which assesses whether the hospital system provided adequate structural conditions for standard compliance. Legal liability is assigned proportionately based on the relative causal contribution of each layer. Where institutional failure is the predominant causal factor—as evidenced in the majority of cases at RSUD Dr. Soeroto

Ngawi—vicarious institutional liability under the respondeat superior doctrine is primary, while where individual professional deviation predominates, personal liability is primary with institutional oversight responsibility remaining secondary. This model offers a more equitable and legally defensible alternative to the binary individual-versus-institution framing prevalent in existing Indonesian health law adjudication.

Despite the existence of a formally structured accountability system, this study identified substantial psychological and procedural barriers that significantly impede nurses' willingness to report incidents openly and honestly. The fear of blame and apprehension regarding disciplinary sanctions constitute the primary factors discouraging transparent incident disclosure, thereby perpetuating a culture of concealment that is antithetical to patient safety principles (Mustofa & Aran, 2025). Many nurses perceive incident reporting as a mechanism for individual performance penalization rather than as an opportunity for organizational learning and systemic improvement. Compounding this issue, reporting formats regarded as unnecessarily complex and the absence of constructive managerial feedback further diminish staff motivation to engage meaningfully with patient safety programs (Dewangga et al., 2025). Collectively, these findings confirm that a genuine just culture has not yet been fully internalized across all service units at RSUD Dr. Soeroto Ngawi, representing a critical gap in the hospital's patient safety governance architecture (Daeng et al., 2023). As a form of proactive risk mitigation, nurses at RSUD Dr. Soeroto Ngawi undertake a range of preventive measures aimed at minimizing the likelihood of errors that could give rise to legal liability. These measures include enhanced adherence to patient identification protocols requiring a minimum of two independent identifiers, as well as the rigorous application of double-check procedures for the preparation and administration of high-alert medications (Hertanto, 2025). Growing awareness of legal risk has also prompted nurses to exercise greater diligence in maintaining comprehensive nursing documentation, recognizing its evidentiary value in potential future disputes. However, the sustained effectiveness of these preventive efforts is substantially contingent upon institutional support in the form of adequate facilities and infrastructure, appropriate staffing levels, and the implementation of humane and evidence-based work scheduling policies (Mahardika, 2026). Ultimately, the achievement of safe, high-quality, and legally sound healthcare services requires an enduring synergy between individual professional responsibility and robust systemic support at the organizational level (Novauzyah, 2026).

Discussion

Forms of Nursing Negligence in the Provision of Healthcare Services That Can Lead to Adverse Events for Patients at RSUD Dr. Soeroto Ngawi

From a legal standpoint, the forms of negligence committed by nurses at RSUD Dr. Soeroto Ngawi constitute failures to comply with the professional and service standards established under Article 273(1) of Law Number 17 of 2023 on Health. Administrative negligence—most notably the misidentification of patients on blood request forms—directly violates the nurse's legal duty to deliver healthcare services in strict accordance with Standard Operating Procedures (SOPs) as mandated by Article 273(2) of the same law. This phenomenon reflects a clear breach of the duty element within medical negligence doctrine, wherein the failure to verify critical clinical data may precipitate misdirected medical interventions with potentially fatal consequences (Alviana et al., 2024). Such lapses in identification protocols are frequently attributable to structural and human factors, including chronic fatigue and excessive workload pressures, which systematically elevate the risk of adverse events in regional hospital settings (Adiana et al., 2023).

Deficiencies in coordination and communication during the patient handover process represent a form of clinical negligence that directly contravenes the patient safety principles enshrined in Article 282(1) of Law Number 17 of 2023. The resultant distortion of clinical information generates critical gaps in the continuity of care that, from a health law perspective, may be characterized as a failure to provide safe and quality healthcare services (Amir & Purnama, 2021). Practices that rely exclusively on routine execution without the application of double-check

procedures for high-risk interventions constitute a form of negligence that disregards the patient's fundamental right to safety (Syahputra & Suminar, 2023). Such conduct represents a deviation from Article 277 of Law Number 17 of 2023, which unequivocally requires healthcare professionals to prioritize patient safety above all competing interests, thereby creating systematic conditions conducive to the occurrence of preventable adverse events (Juliansen et al., 2023).

Specifically, negligence in conducting rigorous clinical observations and inaccuracies in the completion of medical documentation constitute violations of Article 296 of Law Number 17 of 2023, which imposes a mandatory obligation on healthcare workers to maintain accurate and complete medical records. Deficient documentation is not merely a technical oversight; it represents the deliberate or negligent elimination of indispensable legal evidence required to determine the precise scope of medical personnel's liability in the event of a dispute (Hartono & Indrawati, 2025). Within the institutional context of RSUD Dr. Soeroto Ngawi, insufficient meticulousness in nursing care documentation significantly complicates the investigative process whenever patient safety incidents arise (Mustofa & Aran, 2025). Legal enforcement in relation to this form of negligence demands a rigorous and nuanced analysis capable of distinguishing between unavoidable inherent medical risks and errors arising from a demonstrable failure to exercise the standard of due care in nursing practice (Dewangga et al., 2025).

Mitigation strategies addressing these forms of negligence must be anchored in Article 283 of Law Number 17 of 2023, which expressly mandates the implementation of a comprehensive patient safety system through proactive clinical risk management. Strengthening nurses' legal literacy with respect to the provisions governing professional protection and sanctions under the latest regulatory framework is an urgent institutional priority for reducing the incidence of adverse events (Widjaja, 2025). Healthcare institutions are obligated to provide the facilities and infrastructure necessary to support full compliance with service standards, so that nurses are able to fulfill their legal obligations optimally without being constrained by unreasonable workloads or inadequate resources (Ivan et al., 2025). By reinforcing an understanding of Article 441(1) of Law Number 17 of 2023—which affords legal protection to healthcare workers who discharge their duties in accordance with applicable professional standards—it is anticipated that nurses at RSUD Dr. Soeroto Ngawi will be more willing to report and rectify any form of negligence transparently and without fear of unjust reprisal (Mahardika, 2026).

Forms of Liability for Nurses Providing Healthcare Services That Result in Adverse Events for Patients at RSUD Dr. Soeroto Ngawi

At RSUD Dr. Soeroto Ngawi, nurses demonstrate their professional accountability during adverse events primarily through immediate clinical interventions directed at stabilizing the patient's condition and preventing further harm. Pursuant to Article 273(1) of Law Number 17 of 2023, healthcare workers bear a non-derogable obligation to provide services in accordance with applicable professional standards for the purpose of ensuring patient safety (Hertanto, 2025). In this institutional context, nurses function as the first line of clinical defense, bearing primary responsibility for risk mitigation and the execution of emergency medical interventions within the limits of their professional competence (Sutedja et al., 2023). This professional commitment constitutes concrete evidence of the nurse's fulfillment of the duty of care, serving to mitigate the adverse physical consequences sustained by the patient (Rahardianto & Adriano, 2024). Crucially, life-saving clinical actions are appropriately prioritized over administrative documentation procedures, in full conformity with the ethical imperative of primum non nocere that underpins all healthcare practice (Sari, 2025).

Beyond the clinical domain, nurses are legally required to discharge their administrative accountability by reporting incidents honestly and comprehensively through the Patient Safety Incident Reporting System (IKP). This obligation is grounded in Article 282(1) of Law Number 17 of 2023, which mandates the operationalization of a patient safety system through transparent and timely reporting mechanisms (Mu'ammar et al., 2024). Reports submitted within the prescribed

maximum period of 48 hours provide the essential evidentiary basis upon which the Quality and Patient Safety Committee conducts investigations and root cause analyses (Mardhika & Mufidi, 2023). The integrity and transparency of this reporting process represent a pivotal form of accountability, as they enable the institution to determine whether a given incident was precipitated by systemic failure or by individual professional negligence (Shihab, 2025). Accurate and contemporaneous documentation at this stage serves simultaneously as an instrument of professional protection for the nurse and as a critical foundation for institutional learning in the event of future medical disputes.

A further and equally significant dimension of nurses' accountability consists of their active participation in the formulation and implementation of corrective and preventive action plans. This responsibility is directly anchored in Article 283 of Law Number 17 of 2023, which obligates healthcare facilities to engage in proactive, evidence-based clinical risk management (Prayuti et al., 2024). Nurses bear individual and collective responsibility for the strict and consistent application of patient safety standards—including two-factor patient identification protocols and structured interprofessional communication using the SBAR method—as primary safeguards against the recurrence of incidents (Siregar et al., 2023). Collaborative engagement with physicians, pharmacists, and other members of the multidisciplinary clinical team also constitutes a form of collective professional accountability in maintaining and continuously improving the standard of inpatient care (Ivan et al., 2025). The provision of transparent, empathetic, and timely communication to the patient's family further represents a manifestation of the nurse's moral and professional responsibility to preserve public trust in the integrity of the healthcare system (Novauzyah, 2026). The ultimate legal basis for nurses' accountability is provided by Article 441(1) of Law Number 17 of 2023, which affords legal protection to healthcare professionals who discharge their clinical duties in full conformity with prevailing professional standards (Mustofa & Aran, 2025). While hospitals bear vicarious liability for the negligent acts of their employed healthcare staff under the doctrine of respondeat superior, individual nurses nonetheless remain personally and professionally accountable for any conduct that deviates from established SOPs and clinical guidelines (Rahardianto & Adriano, 2024). The continuous enhancement of clinical competencies through targeted training programs, patient safety simulations, and structured professional development constitutes an ongoing and indispensable form of professional accountability aimed at minimizing exposure to legal sanctions (Shihab, 2025). This dimension is of particular significance given that the establishment of liability in any medical negligence case requires objective, evidence-based proof of fault before a competent legal authority (Alviana et al., 2024). The enduring synergy between individual professional responsibility and institutional systemic compliance ultimately serves as the foundational cornerstone of legal certainty for nursing professionals in Indonesia (Hartono & Indrawati, 2025).

However, it must be emphasized that individual professional accountability cannot be evaluated in isolation from the institutional conditions within which nurses operate. The Dual-Layer Accountability Model generated by this study posits that individual and institutional responsibilities are not competing but mutually constitutive: a nurse's capacity to fulfill professional duties is directly contingent upon the adequacy of systemic support provided by the hospital, while institutional safety systems can only function effectively when individual nurses possess the competence and commitment to operationalize them. This bidirectional interdependence means that legal liability determinations must always account for both layers simultaneously, rather than defaulting to individual blame in the absence of a thorough systemic investigation.

Challenges and Efforts to Address Nurses' Liability for Medical Incidents at RSUD Dr. Soeroto Ngawi

The most significant challenge confronting the effective operationalization of nurses' accountability at RSUD Dr. Soeroto Ngawi is the pervasive presence of psychological barriers

rooted in a deeply entrenched blame culture. Nurses frequently report feeling intimidated from disclosing adverse events transparently, driven by well-founded fears of disciplinary consequences, downgraded performance evaluations, and lasting reputational damage within their professional community (Mustofa & Aran, 2025). This psychological impediment is further compounded by administrative reporting procedures perceived as disproportionately complex and time-consuming, particularly under the relentless pressures of a high-acuity clinical workload (Mardhika & Mufidi, 2023). As a direct consequence, a substantial proportion of incidents go unreported or are documented incompletely, fundamentally undermining the systemic investigation process mandated by Article 282(1) of Law Number 17 of 2023 (Daeng et al., 2023). The additional fear of being stigmatized as professionally incompetent by peers and supervisors further entrenches underreporting as a systemic organizational phenomenon that poses profound risks to patient safety governance.

Beyond psychological impediments, a range of systemic and structural obstacles—most notably insufficient managerial support and inadequate institutional infrastructure—continues to undermine the overall effectiveness of accountability mechanisms. Although Article 283 of Law Number 17 of 2023 expressly requires hospitals to implement proactive and comprehensive risk management systems, persistent budgetary constraints in regional public hospitals frequently impede the procurement and maintenance of essential patient safety technologies and digital reporting platforms (Ivan et al., 2025). The absence of a robust and meaningful feedback loop from the Quality and Patient Safety Committee in response to submitted incident reports engenders a pervasive perception among nursing staff that reporting is a hollow administrative formality devoid of substantive organizational consequence (Prayuti et al., 2024). The critically high nurse-to-patient ratios in intensive and high-dependency care units precipitate chronic physical and cognitive fatigue, which measurably diminishes concentration levels and erodes adherence to established operational standards over time (Av, 2025). This structural reality creates an acute legal dilemma wherein nurses are simultaneously required by law to practice in strict conformity with professional standards while operating within institutional environments that are demonstrably incapable of supporting compliance with those same standards (Hertanto, 2025).

In response to these multifaceted challenges, the management of RSUD Dr. Soeroto Ngawi has initiated a systematic program aimed at embedding the principles of just culture within the hospital's patient safety governance framework. This transformative cultural initiative is designed to fundamentally reorient institutional focus—shifting from the attribution of individual blame toward the rigorous identification of systemic weaknesses that constitute the root causes of adverse events (Juliansen et al., 2023). This cultural reform is substantiated and reinforced by the legal protections afforded to healthcare workers who act in full conformity with professional standards, as explicitly provided under Article 441(1) of Law Number 17 of 2023 (Widjaja, 2025). Periodic legal outreach sessions addressing healthcare law and whistleblower protection are conducted with the specific objective of building staff confidence in the credibility, impartiality, and integrity of the internal reporting system (Mahardika, 2026). By deliberately cultivating a non-punitive and psychologically safe work environment, the institution aspires to achieve meaningful improvements in incident reporting transparency—ultimately advancing patient safety outcomes across all clinical service units.

At the operational level, concerted technical efforts have been directed toward streamlining and digitizing the incident reporting process, with the explicit goal of substantially reducing the administrative burden on frontline nursing staff. The deployment of an accessible, user-friendly electronic reporting system enables incident documentation and initial investigations to be initiated more expeditiously, thereby facilitating the timely implementation of corrective recommendations before further harm can occur (Mu'ammar et al., 2024). Simultaneously, continuous and structured training on professional ethics, clinical risk management, and malpractice prevention is actively promoted as a cornerstone of institutional strategy to enhance

nurses' professional autonomy and clinical decision-making competence (Sutedja et al., 2023). It must be noted, however, that training alone is insufficient to reduce nursing negligence in a sustainable manner. The findings of this study demonstrate that training interventions produce meaningful behavioral change only when accompanied by concurrent systemic reforms, specifically: the normalization of nurse-to-patient workloads to levels that permit standard compliance; the implementation of non-punitive incident reporting mechanisms that incentivize transparency; the provision of adequate clinical infrastructure; and the establishment of responsive managerial feedback systems. In the absence of these structural enablers, training programs generate knowledge gains without translating into consistent clinical behavioral change under high-pressure operational conditions, thereby failing to address the root institutional causes of negligence identified in this study (Mustofa & Aran, 2025; Putri & Mannas, 2023).

The prioritization of mediation-based dispute resolution mechanisms provides a degree of legal certainty in the management of medical conflicts, while preserving the therapeutic and collegial relationships among nurses, hospital administration, and patients and their families (Sari, 2025). The interaction between individual nurses' professional responsibilities and hospital system support in preventing errors is fundamentally synergistic rather than substitutive. Individual competence and institutional infrastructure are not alternative pathways to error prevention but mutually necessary conditions: nurses cannot perform to professional standards within systems that structurally preclude compliance, and hospitals cannot achieve patient safety outcomes through governance mechanisms alone without professionally capable and legally aware nursing staff (Daming & Julwanda, 2022; Putri & Mannas, 2023). This study finds that the most significant error-prevention gains at RSUD Dr. Soeroto Ngawi were achieved where individual professional commitment and institutional structural support reinforced one another—specifically in units where both adequate staffing and a supportive reporting culture co-existed. This finding carries a direct policy implication: interventions targeting error reduction must simultaneously address both the individual professional development dimension and the institutional systemic support dimension, as investment in either dimension alone yields suboptimal and unsustainable results. The sustained synergy between each individual nurse's unwavering professional commitment and robust, evidence-based institutional managerial support constitutes the indispensable foundation for resolving legal accountability challenges in a manner that ensures substantive justice, equitable outcomes, and systemic improvement for all parties involved (Novauzyah, 2026).

CONCLUSION

The findings of this study indicate that the legal liability of nurses at RSUD Dr. Soeroto Ngawi regarding adverse events constitutes a form of accountability that integrates life-saving clinical actions with the administrative obligation to report incidents through the IKP system, as mandated by Articles 273 and 282 of Law No. 17 of 2023 on Health. Although the regulatory framework provides legal protection through Article 441 for healthcare workers who act in accordance with professional standards, the implementation of accountability in the field still faces significant challenges, including a blame culture, psychological barriers, and an unbalanced workload. The primary novelty of this study lies in the formulation of the Dual-Layer Accountability Model, which proportionately assigns legal liability between individual professional conduct and institutional systemic failures—advancing beyond the binary individual-versus-institution framing prevalent in existing Indonesian health law scholarship. Theoretically, this model contributes a new analytical framework for interpreting the four classical negligence elements within their institutional context, demonstrating that duty, breach, causation, and damage cannot be assessed independently of the systemic conditions in which nursing practice occurs. Practically, the findings carry direct implications for patient safety policy in regional hospitals: hospital management must simultaneously address both accountability dimensions by adopting a non-punitive just culture, normalizing nurse-to-patient staffing ratios, digitalizing incident reporting systems, and

establishing protected whistleblower mechanisms under Article 441—recognizing that training interventions alone, without concurrent systemic reform, are insufficient to produce sustainable reductions in nursing negligence and adverse events across Indonesia's regional public hospital network.

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