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Factors Affecting the Implementation of Patient Safety Culture at RSI Unisma Malang

Budi Susatia[1(CA)], Kusbaryanto[2], Sri Sundari[3], Chyntia Vicky Alvionita[4]
[1(CA)]Department of Nursing, Poltekkes Kemenkes Malang, Indonesia; budisusatia@poltekkes-malang.ac.id (Corresponding Author)
[2]Faculty of Medicine and Health Sciences, Universitas Muhammadiyah Yogyakarta, Indonesia; kusbaryanto@umy.ac.id
[3]Faculty of Medicine and Health Sciences, Universitas Muhammadiyah Yogyakarta, Indonesia; sundari_purbo@umy.ac.id
[4]Department of Applied Health Sciences, Poltekkes Kemenkes Malang, Indonesia; chyntia_va@poltekkes-malang.ac.id

ABSTRACT

Patient safety culture is an important aspect in providing quality health services. However, in Indonesia, many hospitals have not yet reported data on patient safety incidents. The purpose of this study was to determine the factors that influence the application of patient safety culture at RSI Unisma (Unisma Islamic Hospital), Malang. The research used was mix methods. Feelings of fear and anxiety were one of the biggest factors that can influence the application of a safety culture, especially incident reporting. Fear of being blamed could be caused by a patient safety culture that has not become a habit and has not been maximally socialized.

Keywords: patient safety culture; patient safety; incident reporting

INTRODUCTION

Since the 1990s hospitals have become increasingly aware of the importance of improving the quality of care and patient safety, as a result many have implemented interventions to reduce the number of adverse events and WHO has indicated patient safety as a priority in the health care system [(1)].

Based on this, patient safety is a core component of patient care. However, a number of medical errors still occur frequently in health facilities [(2)] and are considered the leading cause of death globally and are considered the third leading cause of death in the United States [(3)]. About 10% of hospitalized patients in high-income countries experience Medical Error (ME) or medical side effects. According to published reports, ME is one of the main causes of increased complaints in hospitals [(4, 5)].

According to several studies, the causes of ME are lack of job training and experience, fatigue, stress, heavy workload, and lack of communication among health professionals, with a lack of medical knowledge [(6, 7)].

As happened at ESwatini. According to WHO [(8)], Eswatini is one of the top countries with high mortality and morbidity, as many as 464 men and 338 women per 1000 population. Due to this, patient safety is a major concern in this country. The majority of doctors and the public believe that 5000 or more deaths in hospital each year are due to preventable medical errors [(9)].

The World Health Organization (WHO) estimates that tens of millions of patients worldwide experience disabling injuries or deaths each year that can be directly attributed to unsafe medical practices and care. Hospital employees especially nurses and doctors play an important role in maintaining and promoting patient safety due to the nature of their work [(10)].

Adapted from IOM (Institute of Medicine) in 2000 the United States reported 2 studies on KTD in hospitals, "TO ERR IS HUMAN, Building a Safer Health System". It was found that the KTD rates were 2.9% and 3.7%, with a mortality rate of 6.6% and 13.6%. With this data then calculated from the number of hospitalized patients in hospitals in the United States of 33.6 million per year, the mortality rate of inpatients due to adverse events throughout the United States ranges from 44,000 to 98,000 per year.

The National Patient Safety Agency estimated in 2017 that there were 1,879,822 patient safety incidents reported in the UK between January and December 2016. Ministry of Health Malaysia, 2013 reported the number of patient safety incidents in the period January-December as many as 2,769 incidents.

In Indonesia, many hospitals have not reported data on patient safety incidents. The results of research conducted by Nurmalia & Nivalinda [(11)] stated that the management function was in the unfavorable category, namely the planning function (53.1%), and the organizing function (65.6%). %). The directive function is in a stable condition and the control function is considered good (56.2%). Meanwhile, for the implementation of

mentoring, 56.2% of respondents stated that the mentoring that had been carried out was deemed not properly organized. The control function has the strongest influence in the implementation of patient safety mentoring.

Based on the results of research conducted by Jenita, it was found that 28.5% said that nurses did not report Patient Safety Incidents (IKP), 42.8% said nurses reported IKP and 28.8% said nurses sometimes reported incidents and sometimes also does not depend on the incident that occurred at Prof. DR. W. Z. Johannes Kupang-NTT [(12)].

KPP RS in 2011 reported that cases of KTD were 14.41% and KNC was 18.53% due to clinical processes or procedures of 9.26%, medication by 9.26%, and patients falling by 5.15%.

It was reported that the number of hospitals reporting patient safety incidents in 2015 was still low, only 14 hospitals, then increased in the following years and experienced a significant increase in 2019, which was 334 hospitals. In 2015, the number of patient safety incidents reported was 289 cases, while in 2019 there was a significant increase of 7465 cases.

Based on the 2012 RSI Unisma report, it is known that the incidence of falling patients is still high, which is in the fourth place of all patient safety incidents. In 2013, a fall risk management policy or program has not yet been formulated, including the standard operating procedures for the management of falling risk patients.

Based on the background, phenomena, and the lack of reporting of hospital data on patient safety, the purpose of this study is to examine the factors that influence the application of Patient Safety culture at RSI Unisma Malang.

METHODS

The research used mix methods, which combines quantitative and qualitative research. The subjects in this study were general practitioners and specialists, nursing staff, and medical support personnel at RSI Unisma Malang. In this study, the object of research was the application of patient safety culture.

The total population were 325 people. Samples were calculated by RAOSOFT software with an error margin of 0.05 and a confidence interval of 0.95. After being calculated, the number of samples obtained was 177 respondents, selected using simple random sampling.

The research instrument was a questionnaire consisting of 12 HSOPSC dimensions with a total of 42 question items which were translated from the English version into Indonesian. Structured interviews were used in this study to obtain information directly through question and answer with informants, so as to get clearer information about the obstacles in implementing patient safety culture at RSI. Unisma Malang.

RESULTS

RSI Unisma was founded with the background of the thought of the Management of the Malang Islamic University Foundation and all religious scholars in the Greater Malang area on the demands of the need for health services for the community in general. RSI Unisma Malang has 325 health workers consisting of General Practitioners and Specialists, Nursing Staff, and Medical Support Staff.

Table 1. The characteristics of respondens

No	Characteristics of Respondents	Frequency	Percentage
Gender			
1	Male	48	27,1
2	Female	129	72,9
Age Classification (Years)			
1	20 -24	38	21.5
2	25-29	65	36,7
3	30-34	18	10,2
4	35-39	17	9,6
5	40-44	29	16,4
6	45-49	9	5,1
7	50-54	1	0,6
Level of Education			
1	Medical	2	1,13
2	Nursing	74	41,81
3	Nursing Profession	14	7,91
4	Diploma 3 of Midwifery	4	2,26
5	Diploma 4 of Midwifery	10	5,65
6	Radiology	2	1,13
7	Diploma 3 of Nutrition	6	3,39
8	Diploma 4 of Nutrition	5	2,82
9	Diploma 3 Medical Records	2	1,13
10	Etc	60	32,77
Work Experience (Years)			
1	1 - 3	41	23,3
2	3 - 5	56	31,8
3	5 - 10	42	23,9
4	≥10	37	21

Based on table 1 the largest proportion is women as many as 129 respondents (72.9%). For the level of education, the highest proportion was D3 Nursing as many as 74 respondents (41.81%) and the lowest proportion was S1 Medicine and D3 Medical Records as many as 2 respondents (1.13). Work experience, the highest proportion is 3-5 years as many as 56 (31.8%), and the lowest is ≥10 years as many as 37 (21%) Analysis of the factors that influence the application of patient safety culture.

Feelings of Anxiety and Fear

Feelings of fear and anxiety are closely related to a nonjudgmental response to mistakes. The nonjudgmental response to error is the strongest factor influencing the adoption of a patient safety culture at RSI Unisma Malang. The following is a quote about a nonjudgmental response to an error.

Table 2. Nonjudgmental response to an error

Theme	Quotation
Worried about reporting incidents	*"Biasanya masih ada kekhawatiran dari beberapa SDM untuk melaporkan." (Informan C)"* "Usually there are still concerns from several human resources to report. "(Informant C)" *"Masih ada yang takut untuk lapor, perlu edukasi sih tentang pelaporan IKP harus terus ditingkatkan" (Informan F)* "Afraid to report, need education about reporting of patient safety incidents and must continue to be improved "(Informant F)
Lack of employee motivation	*"Kurangnya motivasi melapor dari pegawai untuk setiap insiden terutama bagi yang mengetahui. Mungkin takut begitu" (Informan A)* "Lack of motivation to report from employees for every incident, especially for those who know. Maybe afraid" (Informant A) *"Belum terlaksana maksimal kalau menurut saya. Ya karena tidak semua mau melaporkan kejadian. Dan tingkat kepeduliannya yang masih rendah" (Informan B)* "It hasn't been done optimally in my opinion. Because not everyone wants to report the incident. And the level of concern is still low "(Informant B)

From the results above, it can be concluded that health workers are still worried and afraid to report if a patient safety incident occurs, most likely because they are afraid of being judged or punished by their superiors or management at RSI Unisma Malang.

Reporting patient safety incidents is not merely a safety incident reporting, but the reporting should be followed up to correct errors and find the root of the problem, not to punish those who make mistakes or affect their performance evaluation.

Communication

Based on the results of the study, officers are free to express opinions, free to ask about decisions or actions to be taken, but still feel afraid to ask questions if there are incidents that occur in patient care. This is supported by the statement from the informant as follows:

"Komunikasi kita cukup terbuka, saat ini memang sedang proses peningkatan. Tapi memang kalo mau tanya pas ada insiden memang rada takut. Mungkin takut atau gimana gitu" (Informan K)
"Our communication is quite open. Currently, we are in the process of improving it. But if you want to ask when there is an incident, it's a bit scared. Maybe afraid or something "(Informant K)

Communication can be applied at the time of the operand or handover of patients, nursing rounds, and briefings before carrying out activities. At the time of handover, health workers are expected to be able to communicate openly by communicating to other health workers about the risk factors for an incident.

Feedback

Based on the results of the study, the manager provides feedback every time an incident occurs. However, response time in the follow-up is still considered quite long, as evidenced by the results of the response that are less than 75% regarding this matter. This shows that the feedback and communication of errors at RSI Unisma Malang are not running optimally. This is supported by the statement from the informant as follows:

"*Evaluasi berkala ya ada, cuma kalau untuk feedback ke kita nya itu agak lama" (Informan D)*
"There are periodic evaluations, but for feedback to us it's a bit long" (Informant D)

Feedback and communication of errors is of utmost importance after reporting a patient safety incident.

DISCUSSION

Feelings of Anxiety and Fear

Feelings of fear and anxiety are closely related to a nonjudgmental response to mistakes. The nonjudgmental response to error is the strongest factor influencing the adoption of a patient safety culture at RSI. Unisma Malang. Staff assume that mistakes made regarding patient safety incidents will be recorded in the staffing data so that there is a sense of concern for health workers in reporting incidents. Whereas errors that are not reported will have an impact on the loss of opportunities for learning organizations, change and develop from existing patient safety problems [(13)].

When an incident occurs, it should not focus on finding individual faults but rather study the system that causes errors to occur [(14)]. The fear of being blamed can be caused by a patient safety culture that has not become a habit and has not been maximally socialized in all hospitals.

Communication

Communication has an important meaning in patient safety and continuity of care. Communication is a process of delivering messages (information, ideas, ideas, statements) from staff without fear or freedom to express opinions, both regarding the action decided or if they see something that has a negative impact that can affect the patient to affect the patient.

Organizations with a positive patient safety culture have open and trusting communication, shared perceptions of the importance of patient safety, and measures the effectiveness of prevention. Patient safety is protected through patient safety standards and increased application of patient safety by nurses due to the implementation of safety including patient identification, effective communication at the time of receipt, avoiding drug administration errors, eliminating procedural errors, preventing nosocomial infections, and prevention of falling patients.

Providing the opportunity to ask questions can be a positive cause and significant influence of communication is due to the leadership always giving the staff the opportunity to ask questions about work problems that are considered truly important. Briefing is one way to improve communication to share information about patient safety that can potentially occur in daily activities at RSI Unisma Malang.

Feedback

According to Hamdani [(15)], reporting can only provide benefits if it is responded to in a constructive manner. Response means providing feedback from incident reporting in the hope that there will be corrective action to the ongoing patient safety system. Feedback and communication to all staff after an analysis of incident reporting is very important for hospital management. According to Dignen [(16)], the absence of feedback is evidence of communication failure. Feedback is also an opportunity to learn from what was previously communicated.

CONCLUSION

The factors that influence the implementation of patient safety culture at RSI Unisma Malang include: Feelings of anxiety and fear of reporting incidents, open communication and feedback from management as a result and immediate improvements to the ongoing patient safety system.

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