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Original Research Article

Implementation of patient safety culture in outcome level in X general hospital in Yogyakarta

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ABSTRACT

Background: Creating a culture of patient safety is something that must be considered. This is because culture contains two important components, namely values and beliefs that can change organizations. Most safety incidents of Yogyakarta District Hospital in 2018 were 21 near miss incidents, incidents in total, then 17 incident, not injured and 5 events in unexpected events, while in potential injured there were no incidents during 2018. In 2018 there were still several months of data that had not yet met patient safety incident targets. From a preliminary study the researcher obtained, data on patient safety incident reporting has not been optimally performed by nurses. The purpose of this study was to determine the implementation of patient safety culture at the outcome level.
Methods: This research is mixed methods research with an explanatory sequential design. Primary data obtained from in-depth interviews, a description of the implementation of patient safety culture at the Outcome level data obtained from questionnaires given to 72 nurses.
Results: The culture of patient safety Yogyakarta District Hospital has been implemented well. At the level of patient safety culture outcomes related to the frequency of reporting patient safety events have been carried out but related to incidents that have no potential for injury when reporting is not appropriate, the perception of patient safety at the patient safety level, the number of reporting of events at the Yogyakarta District Hospital has been carried out properly.
Conclusions: The safety culture of patients at Yogyakarta District Hospital at the outcome level has been implemented well.

Keywords: Culture, Outcome, Patient safety

INTRODUCTION

Patient safety is an important and global issue in health services such as hospitals, therefore, patient safety is a top priority to be implemented and it is related to the occurrence of patient safety incidents in hospitals. Many hospitals have begun to run various programs and pay attention to patient safety cases.[1,2] Patient safety is a variable to measure and evaluate the quality of health services that have a path to health care. The patient safety program aims to reduce the number of unexpected events (KTD) that often occur in patients during hospitalization so that it is very detrimental to the patient and can also be detrimental to the hospital.[3] Patient safety is not yet a culture by health care service organizations. Unexpected events (KTD) such as the phenomenon of the iceberg, Efforts to develop factors that support a patient safety culture need to continue to be promoted by health service providers.[4] Reports on patient safety incidents in Indonesia were found to have reported cases of unwanted

events of 14.41% and nearly accidental incidents of 18.53% as for various causes, namely due to clinical processes or procedures of 9.26%, medication of 9.26% and patients falling by 5.15%.[5]

Creating a culture of patient safety is something that must be considered. This is because culture contains two important components, namely values and beliefs that can change organizations. Patient safety culture is divided into three levels, namely unit level, hospital level and outcome level.[6] The results of previous studies at Yogyakarta District Hospital obtained data that there is no relationship between nurses 'knowledge with patient safety goals, but there is a relationship between nurses' attitudes and patient safety goals.[7] Most safety incidents of Yogyakarta District Hospital in 2018 were 21 near miss incidents (KNC), 21 incident not injured (KTC), 5 unexpected events (KTD), while in potential injured (KPC) here were no incidents during 2018. Patient safety events still occurred at Yogyakarta District Hospital caused by misunderstanding of communication inside and outside the unit, and understanding of officers who assume that the patient's concern is not one of the main things and the concentration of officers is divided because many things must be dealt with simultaneously so the time to make a report of an incident is limited. In 2018 there are still several months of data that have not met the target of patient safety incidents. From the preliminary study, the researcher obtained data on patient safety incident reporting that was not optimally carried out by nurses, so researchers wanted to conduct a survey related to patient safety culture, especially at the outcome level.

METHODS

This research is mixed methods research with an explanatory sequential design. This research was carried out in the Yogyakarta district hospital, from April to September 2019. Primary data were obtained from in-depth interviews, subjects in this study were the chairperson of the patient safety committee, the secretary of the patient safety committee, the head of ward A and ward B, the head of the ICU room, the head of the emergency room, the head of the outpatient room, the head of the pharmacy office, the head of the PPI secretary and 1 general practitioner. A description of the implementation of patient safety culture at the outcome level data was obtained from a questionnaire given to 72 samples, the sample in this study are nurses, with criteria inclusion are the nurse has been working for 2 years and received patient safety training.

The data from the questionnaire were processed with SPSS in the form of a description of the outcome level of patient safety culture. This study has passed a review of ethical clearance by Yogyakarta district hospital with ethical approval number 31/KEP/RSU/VII/2019.

RESULTS

The results of the research on patient safety culture implementation at the outcome level are presented in each sub-level as in following sections.

Frequency reporting of patient safety events

Based on Table 1 it is found that 60% of the frequency of reporting of patient safety events is categorized as good while 40% is said to be not good. This result is supported by the results of interviews conducted by researchers. Yogyakarta District Hospital has supported the frequency of reporting of patient safety incidents. Patient safety event reporting is done as soon as possible or a maximum of 2x24 hours since the incident, there are facilities to fill out the reporting form, there is coordination, there is feedback from the patient safety committee, simple flow and all types of patient safety events have been reported. This was stated by respondent B below:

"... the slightest incident reported, yes all types of incidents must be reported ..." (Respondent B).

"... yes, so the report is done filling out the form, then the committee will come here, take the report, then follow up according to the flow ..." (Respondent L).

Patient safety events must be fully reported to the patient safety committee. But there are still some obstacles in the implementation of reporting in Yogyakarta District Hospital such as the delay in reporting the types of events that do not harm patients. This is as stated by the following Respondents:

"... yes, it is reported only sometimes if, if the incident does not endanger the patient, the term is almost like that, it hasn't happened yet, sometimes we are late reporting it a few days later, yes reported ..." (Respondent L).

Table 1: Overview of reporting frequencies (n=72).

No.	Categories	Frequencies	%
1.	Good	43	60
2.	Not good	29	40

Overall perception about patient safety

Based on Table 2 it was found that 72% of the perceptions about patient safety were categorized as good while 28% were said to be unfavourable. This result is supported by the results of interviews conducted by researchers. Yogyakarta District Hospital has supported the perception related to patient safety. The existence of reporting patient safety events by officers as soon as possible, all forms of patient safety events continue to be reported by officers and the existence of patient safety incident prevention activities such as the risk of falls and decubitus. This was stated by Respondent C below:

"... there is an effort, yes we try to minimize it. For example, we ask for a full bed cover so that the patient does not fall so we do it prevention ..." (Respondent C).

"... even the slightest mistake must be reported then we also tell the team in the unit that it's nothing so that in the future it can be a lesson for us ..." (Respondent G).

Table 2: Overall descriptions of patients' safety (n=72).

No.	Categories	Frequencies	%
1.	Good	52	72
2.	Not good	20	28

Patient safety level

Based on Table 3 it was found that 69% of the patient safety level was categorized as good while 31% were said to be unfavourable. This result is supported by the results of interviews conducted by researchers. Yogyakarta District Hospital has provided support related to the level of patient safety at the hospital. There is monitoring from the patient safety committee, the presence of feedback and socialization related to patient safety. Observation results also show that has implemented points in patient safety.

"... well, it's good that feedback is there and what is coordinated with what is distributed to other units is nothing for our lessons ..." (Respondent B).

"... yes, there is good, we have risk management, it's also the prevention of socialization, there is also feedback to the report, I think it's good too ..." (Respondent K).

Table 3: Overview of patient safety levels at hospital (n=72).

No.	Categories	Frequencies	%
1.	Good	50	69
2.	Not good	22	31

Number of patient safety event reports

Based on Table 4 it is found that 60% of the patient safety level is categorized as good while 40% is said to be unfavourable. This result is supported by the results of interviews conducted by researchers. Yogyakarta District Hospital has provided support related to the number of reports of patient safety incidents in hospitals. There is a reward for officers who report and there is motivation for officers. Observation results also show that the general hospital area X has implemented points in patient safety.

"... reporting is done directly later when it is also reported to the director. We will recap the report, if here quarterly ... "(Respondent G).

"... there has never been punished so it is more rewarding, so if you report quickly, you will get a unit reward like that ..." (Respondent G).

Reports carried out during the last 12 months were 76 reports. Nevertheless, the number of reports made by officers does not necessarily clearly reflect the incidence of patient safety in the field. The same thing was expressed by respondents as follows:

"... yes, even so, we don't know that all of the patients did not report the safety of this patient, like an iceberg, yes, you look small, but if you look at it, it is really big ..." (Respondent B).

Table 4: Overview of reports on patient safety events (n=72).

No.	Categories	Frequencies	%
1.	Good	43	60
2.	Not good	29	40

DISCUSSION

Frequency of reporting on patient safety events

The results showed 60% of the frequency of reporting patient safety events was categorized as good while 40% were said to be unfavourable. This result is supported by the results of interviews conducted by researchers that Yogyakarta District Hospital has supported the related frequency of reporting patient safety events with the reporting of patient safety events carried out as soon as possible or a maximum of 2×24 hours after the incident, it is also supported by the reporting form facilities, the existence of coordination and the existence of feedback from the patient safety committee. Knowledge plays an important role in reporting patient safety incidents (IKP). From the research results, it was found that 40% of respondents did not know how to report IKP. Ignorance of how to report causes IKP not to be reported.[8] Other studies have shown that employees, especially nurses, do not report patient safety events because nurses do not fully understand the definition of incidents, causing delays in reporting and incomplete data.[9]

At Yogyakarta District Hospital, the type of patient safety incident must be reported from the relevant unit to the patient safety program for further analysis and learning. In a study by Suparti, et al, the results showed that respondents before being given training only reported a total of 5 reports of types of near miss injuries, unexpected events and potential injuries after in-depth interviews found that participants felt afraid to report, afraid to be blamed, did not know how to report and did not know the benefits of reporting.[10] Motivation has been given in the form of rewards to officers who report patient safety incidents so that it is expected to increase the desire of officers to report events.

Besides, the Yogyakarta District Hospital also has a reporting and feedback system for reporting patient safety incidents, the existing flow has been socialized to all hospital staff and there is a reporting flow poster posted on each hospital unit. Hospital staff report patient safety incidents according to the flow without objection. Surely this feedback will affect the reporting by officers at Yogyakarta District Hospital. This is in line with research by Gunawan that another factor causing the low reporting of patient safety events is the lack of optimal feedback provided by the KPRS team on reporting patient safety events, this condition will hamper in realizing a good patient safety event reporting system.[11]

Work experience at the hospital also impacts the frequency and number of reported events. The frequency of reported events is found to increase with increasing experience. On the other hand, the score for patient safety perception decreases because hospital experience increases. Safety perception is defined as the extent to which procedures and systems are good at preventing errors and lack of patient safety problems. As people become more experienced, they become more aware of patient safety practices, systems, and procedures in hospitals acting as a barrier to errors and problems.[12]

Overall perception about patient safety

Perception regarding patient safety means a person's process of carrying out actions and observations of patient safety based on various components such as reporting patient safety events, steps to prevent patient safety events and increasing patient safety knowledge. Yogyakarta District Hospital illustrates that officers have a positive perception of patient safety. Also at the Yogyakarta District Hospital, efforts have been made to improve the knowledge and understanding of patient safety by conducting periodic training and monitoring from the patient safety committee.

The results showed that 72% of perceptions about patient safety were categorized as good while 28% were said to be unfavourable. This result is supported by the results of interviews conducted by researchers. Yogyakarta District Hospital has supported the perception related to patient safety. The existence of reporting patient safety events by officers as soon as possible, all forms of patient safety events continue to be reported by officers and the existence of patient safety incident prevention activities such as the risk of falls and decubitus.

Officials at Yogyakarta District Hospital have implemented various patient safety cultures such as two-way coordination between patient safety program (PMKP) and the hospital unit, risk management, monitoring by PMKP, and feedback from PMKP regarding reporting of patient safety events. Other studies have shown that there is a negative perception of patient safety among doctors and nurses trained in the intensive care unit. In this study, several safety problems in hospitals were found, one of which was related to errors in reporting and the fear of reporting incidents of patient safety, low job satisfaction and poor communication between nurses and doctors.[13]

Patient safety level

The results showed that 69% of the level of patient safety was categorized as good while 31% were said to be not good. This result is supported by the results of interviews conducted by researchers that in Yogyakarta District Hospital have provided support related to the level of patient safety at the hospital. There is monitoring from the patient safety committee, the presence of feedback and socialization related to patient safety. Observation results also show that District Hospital has implemented points in patient safety. The level of patient safety is a general description of officers' perceptions of patient safety in hospitals. Yogyakarta District Hopital in Yogyakarta has a high positive response this illustrates that efforts to maintain patient safety that have been done by Yogyakarta District Hospital are good. This is in line with research by Elrifda found that respondents gave positive responses about patient safety and most of the officers considered the level of patient safety in their work units to be "sufficient".[14] The level of patient safety requires the attention of management and staff themselves so that in the future patient safety is improved because patient safety is not only important for patients or their families but also affects the existence of institutions in the long run.

In addition to the above, training also affects the level of patient safety, which is derived from actions taken by officers/nurses? Training is a learning process that involves acquiring expertise, concepts or attitudes to improve performance. This is in line with research by Yasmi that the level of patient safety is influenced and has a significant relationship to the culture of learning and the culture of no blame.[15] Training is stated as part of education which involves the learning process to acquire and improve skills outside the applicable education system in a relatively short time. The number of training attended by nurses can be a powerful influence in determining whether a person is good at carrying out patient safety.[16]

Number of patient safety event reporting

The results showed 60% of the level of patient safety was categorized as good while 40% were said to be not good. This result is supported by the results of interviews conducted by researchers at Yogyakarta District Hospital who have provided support related to the number of reports of patient safety incidents in hospitals. There is a reward for officers who report and there is motivation for officers. Observation results also show that District Hospital has implemented points in patient safety. Secondary data obtained from the District Hospital Patient Safety Committee in Yogyakarta shows that there have been reports of patient safety incidents during the past 12 years so that it shows that officers at Yogyakarta

District Hospital have reported when a patient safety incident occurs to the hospital patient safety committee. Hospitals should approach organizations rather than individuals to improve patient safety reporting. Efforts can be made by increasing employee knowledge about how to report IKP, eliminating employee fears about the impact of reporting, fostering a patient safety culture. Other efforts that can be done are to create a good reporting system and provide a fast reporting response and the punishment took is neither blaming nor individual punishment.[17]

The completeness of the data in the patient safety incident report can be seen from the aspects that must be completed in the patient safety incident report form at the hospital. The incident report form consists of a name, medical record number, room, age, cost bearer, gender, and entry fee. In the second aspect, it is about the details of the incident which consists of the time of the incident, the chronology of the incident, the type of incident, the first person to report the incident, the incident occurred to the patient or others. The place of the incident, the work unit that caused the incident, due to the incident, the type of action taken immediately, and the provider of the action. In the third aspect, grading risk. Whereas in the fourth aspect a simple investigation sheet for grading blue or green risk.[18]

Reporting conducted by health workers is one of the important points in patient safety. The level of patient safety and patient safety culture that is already running in a hospital will be illustrated through this amount. This is in line with research by Najihah that reporting patient safety events can improve the application of patient safety culture so that patient safety events can be avoided.[2] All staff is expected to be able to report patient safety incidents, and all components of the organization participate in patient safety. This shows that all components of the hospital must participate in reporting patient safety incidents. This study is not in line with research by Iriviranty which results that the number of reporting in the last 12 months is 48%, it is considered as a patient safety culture which implementation is lacking.[19]

CONCLUSION

The conclusion of this study is level of patient safety culture outcome which includes the frequency of reporting patient safety events, perceptions of patient safety at the patient safety level, the number of incident reports at Yogyakarta District Hospital in Yogyakarta has been carried out not all nurses are in good category so training is needed to increase the knowledge and perception of nurses, especially at outcome level.

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