PATIENT SAFETY CULTURE AND ITS DETERMINING FACTORS (A QUALITATIVE STUDY AT ISLAMIC HOSPITAL OF BANJARNEGARA (RSI BANJARNEGARA)

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ABSTRACT

Health Services at hospital completed with modern technology as well as diagnostic and therapy procedure complexity yet probably risks patient safety, therefore, patient safety today is still a priority issue. Patient Safety is a system that makes patient care safer. Developing patient safety program at hospital is a high challenge for hospital management, in which the most serious difficulty is to make safety culture, a foundation for patient safety program. During the period of 2019 at Islamic Hospital of Banjarnegara (RSI Banjarnegara), there were 19 injury potential cases, 37 Non Injury Cases, 24 Close to Injury Cases and 5 Unpredictable Incident Cases. While in 2020 up to June 2020, there have been 9 injury potential cases, 1 Non Injury Cases, 14 Close to Injury Cases and 18 Unpredictable Incident Cases. The purpose of this study is to identify patient safety culture and its determining factors at Islamic Hospital of Banjarnegara (RSI Banjarnegara) in 2020. Type of this study is phenomenology study using descriptive qualitative approach. Data collection method used is by conducting interviews and reviewing policies/regulations concerning patient safety. Data analysis method used is by data reduction, data presentation, drawing conclusion and verification.

Conclusion : Factors determining patient safety culture at Islamic Hospital of Banjarnegara (RSI Banjarnegara) are among others : availability of manager support, strong commitment from chairperson of committee of Patient‘s Quality and Safety Improvement, patient safety culture understanding at executing level, blaming culture which still exists, reward system in employee performance assessment, sufficient facilities and infrastructure to apply patient safety culture.

Keywords : culture ; patient safety; determining factors.

1. Introduction

The Covid-19 pandemic that is currently happening in Indonesia is currently causing several hospitals to be overwhelmed in handling patients, both from the lack of availability of personal protective equipment (PPE), facilities and infrastructure, as well as the availability of Human Resources so that it has an impact on the safety of officers and patient safety. Meanwhile, the rapid development of technology in the health sector and the complexity of diagnostic and therapeutic procedures that are not matched by equal distribution of training for human resources in the hospital makes it possible to risk injuring patients so that patient safety is currently a priority issue

at the hospital. Patient's Quality and Safety Improvement (Peningkatan Mutu dan Keselamatan Pasien/PMKP) is an important part of Management at the Hospital.

Patient safety is a system that makes patient care safer, including risk assessment, identification and management of patient risks, incident reporting and analysis, the ability to learn from incidents and their follow-up, and implementation of solutions to minimize risks and prevent injuries caused by errors. as a result of carrying out an action or not taking the action that should be taken (Regulation of Minister of Health Number 11 of 2017 concerning Patient Safety).

National Patient Safety Agency 2017 reported that in the period January-December 2016, the number of patient safety incidents reported from the UK was 1,879,822 incidents. Ministry of Health of Malaysia 2013 reported the number of patient safety incidents in the period January-December as many as 2,769 incidents; whereas in Indonesia in the period 2006 - 2011 KKPRS (Komite Keselamatan Pasien Rumah Sakit/Committee Hospital Patient Safety) reported 877 patient safety incidents. The data obtained at Islamic Hospital (RSI) of Banjarnegara in 2019 were 19 cases of potential injury (Kejadian Potensial Cedera/KPC), 37 cases of non-injury (Kejadian Tidak Cedera/KTC), 24 cases of near-injuries (Kejadian Nyaris Cedera/KNC), and 5 cases of unexpected events (Kejadian Tidak Cedera/KTD).

The first Patient Safety Movement emerged in the United States and then on August 21, 2005. Minister of Health launched the Hospital Patient Safety Movement. Accepting patient safety as a new value in organizational culture meaning that every doctor and other health care worker as well as professional organizations must be able to change from a blaming culture if there is a patient safety incident to a safety culture.

Developing a patient safety program in a hospital is a formidable challenge for hospital management because it is not just providing financial resources, human resources, and equipment. The biggest obstacle is how to create a safety culture that is the foundation of a patient safety program. Responses given by superiors who tend to mention names (naming), shaming (shaming) and blaming (blaming) are one of the causes when patient safety incidents at the hospital are not reported (Cahyono, 2008).

Not yet optimal patient safety culture in the hospital is directly related to individual attitudes and motivation to report patient safety incidents. There are several factors related to patient safety culture, such as: managers' perceptions of safety culture, leadership support, working conditions including team work and communication, work environment regarding facilities and work stress, job satisfaction of nurses, nurses' attitudes, nurse knowledge level and nurse motivation. By knowing the factors that affect the patient safety culture will make it easier for hospital management to fix things that hinder the implementation of patient safety culture.

This research was conducted at the Banjarnegara Islamic Hospital in June - August 2020. The general objective of this study is to determine the patient safety culture and the factors that influence it at Banjarnegara Islamic Hospital in 2020. While the specific objectives are: knowing the characteristics of respondents at Banjarnegara Islamic Hospital in 2020, knowing the perceptions of managers about safety culture, knowing leadership support for culture patient safety, knowing the work environment towards patient safety culture, knowing the job satisfaction

of nurses with patient safety culture, knowing the attitudes of nurses towards patient safety culture at Islamic Hospital (RSI) Banjarnegara in 2020.

2. Literature Review

Patient safety is a process at a hospital that provides safer patient services; this includes risk assessment, identification and risk management of patients, incident reporting and analysis, the ability to learn and follow up on incidents, and implement solutions to reduce and minimize the incidence of risk.

Patient safety culture is a product of individual and group values, attitudes, competencies, and behavior patterns that determine commitment, style and ability of a health care organization to the patient safety program. If a health care organization does not have a patient safety culture, accidents can be resulted from latent errors, psychological and physiological problems on staff, decreased productivity, reduced patient satisfaction, and can lead to interpersonal conflicts. Other dimensions that are difficult to be immediately identified including values and assumptions. Dimensions of Patient safety culture include: (1) Openness of communication; (2) Feedback and communication about errors that occur; (3) Frequency of incident reporting; (4) Handoff and transitions; (5) Organizational support for patient safety; (6) Nonpunitive response to errors / responses; (7) Organization learning; (8) Overall perception of patient safety; (9) Staffing; (10) Supervisor / leadership expectations; (11) Cross-unit cooperation; and (12) Cooperation among units / within units.

3. Research methodology

This research is a type of phenomenological research using a descriptive qualitative approach. Methods of data collection was conducted by interviewing nurses, doctors, and Head of the Patient‘s Quality and Safety Improvement Team (PMKP) and reviewing policies / regulations regarding patient safety at Banjarnegara Islamic Hospital, as well as making observations to obtain the required information. The object of this research is the culture of patient safety and what factors have an influence on the culture of patient safety at Islamic Hospital of Banjarnegara (Rumah Sakit Islam/RSI Banjarnegara). The subjects in this study were health personnel in the inpatient installation of Islamic Hospital of Banjarnegara (RSI Banjarnegara). The population is all employees of the Islamic Hospital of Banjarnegara (RSI Banjarnegara), namely the Board of Directors, doctors and nurses and other supporting staff. Participants were selected purposively for interviews through Focus group discussions (FGD) and then continued with an in-depth interview with the RSI Director, Head of the Patient‘s Quality and Safety Improvement Team (PMKP), and senior midwives who were key figures.

The analysis carried out is inductive in nature to obtain meaning, understanding, concepts, and to develop new hypotheses. The analysis was carried out by organizing the data that had been obtained, describing them into units, synthesizing and arranging them into patterns, separating the important and less important things. The process is carried out interactively and continuously in order to obtain saturated data. The qualitative data analysis method used is the Miles and Hubberman model, which is carried out in 3 stages: data reduction, data display, and conclusion drawing / verification.

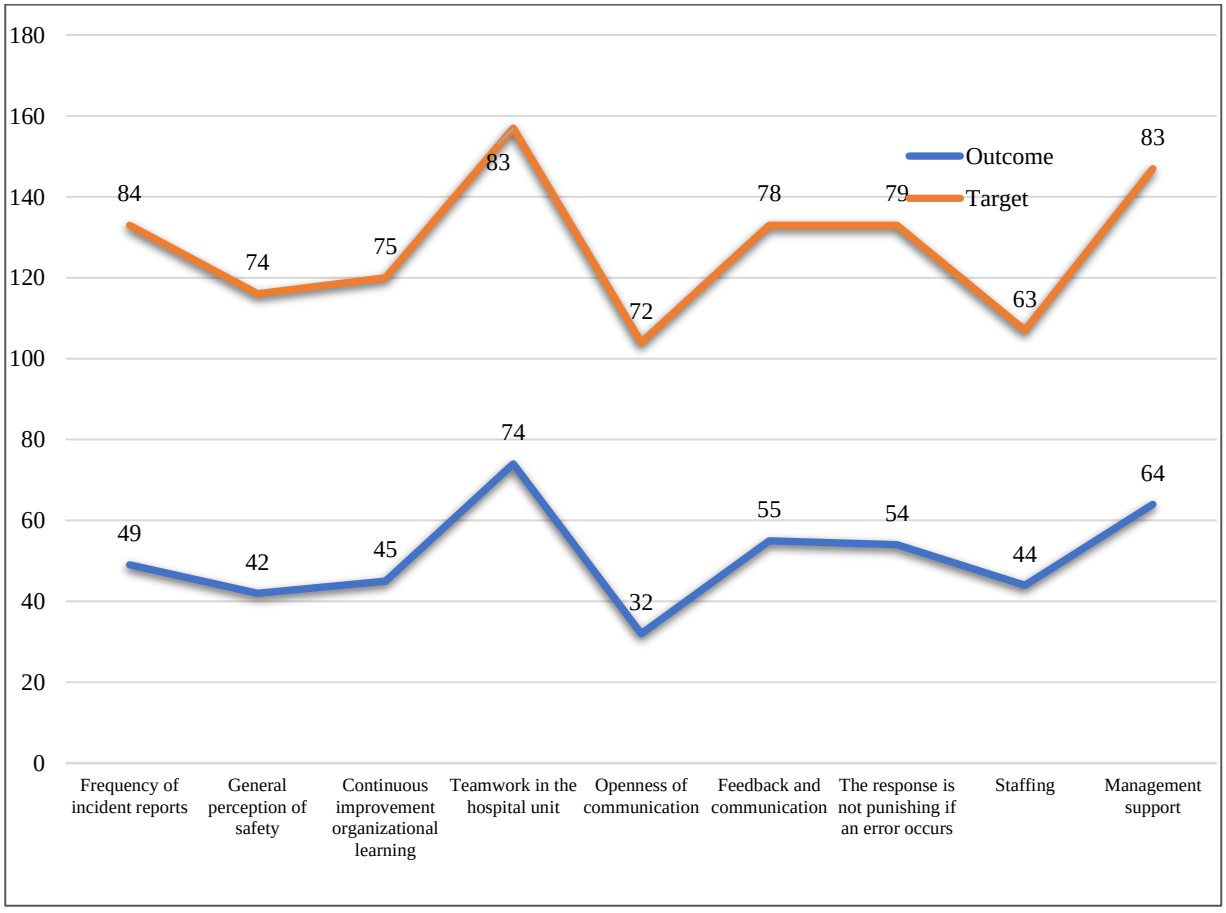
Primary data were obtained directly from participants by conducting interviews through focus group discussions (FGD) and in-depth interviews, while secondary data were obtained from the Health Office of Banjarnegara Regency, reviewing regulatory / policy documents at RSI and observing conditions at the Islamic Hospital of Banjarnegara.

4. Results and Discussion

4.1 General description

RSI (Islamic Hospital) is a business entity owned by the Jamaah Haji Banjarnegara (Haj Pilgroms of Banjarnegara) Foundation which was established on June 1, 1983 with the initial status of a polyclinic and became a hospital on November 2, 1992. The total number of employees in 2020 was 350 people with 138 nurses, 26 midwives. The work unit consists of: Surgery Room, Emergency Installation Room, Inpatient Care Units (9 units), Outpation Care Units (13 polyclinic), Laboratory, Pharmacy Room, Administration Room and ICU room.

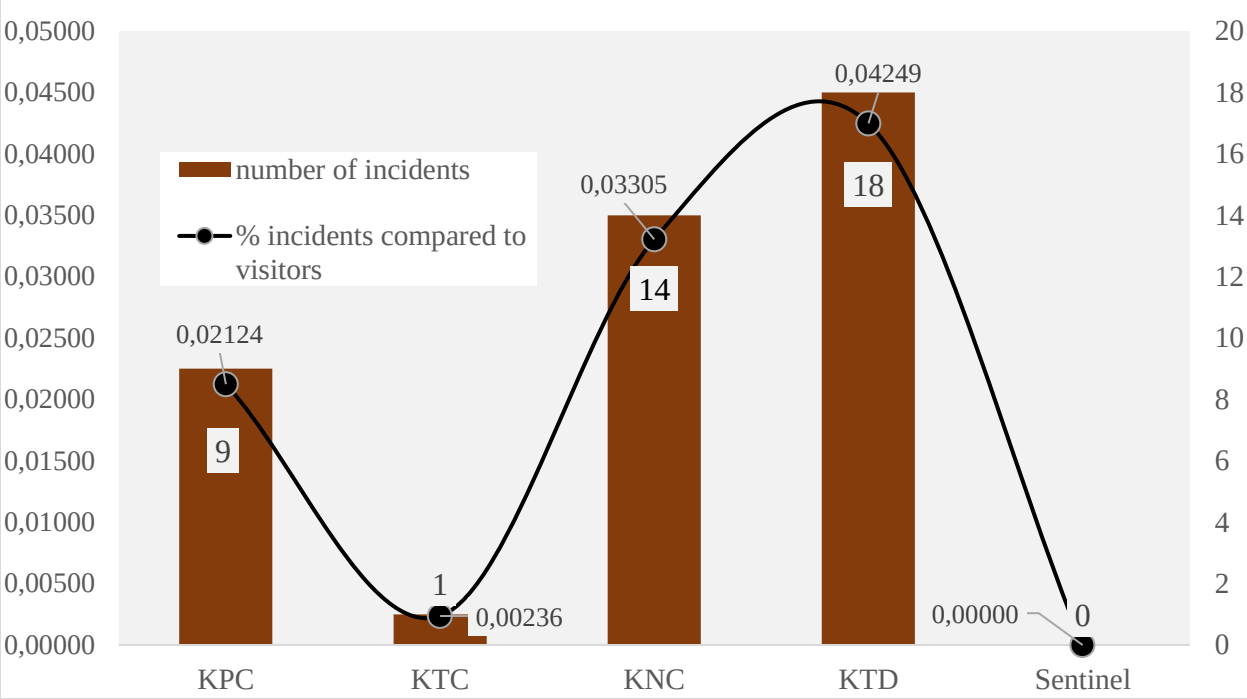
Figure 1 : Graph of patient safety culture survey results Year 2019 (Yield and Target in%)



The policies adopted by RSI to support patient safety culture include: Guidelines for the organization and work procedures of PMKP (Peningkatan Mutu dan Keselamatan Pasien/Patient‘s Quality and Safety Improvement) which includes RSI's Vision and Mission, Motto, 10 Cultures and 7 values that must be implemented by all employees. There is a schedule of meetings, namely

the PMKP Team that is once per month, PMKP committee meetings with the board of directors once 4 months, meetings with related units once 4 months. The PMKP committee makes reports to the director in written form after each activity, then the PMKP work program evaluation report is carried out annually.

Figure 2 : Number of incidents and % of incidents compared to number of visitors in 2020



4.2 Patient safety culture

The RSI Patient Safety Culture Guide contains dimensions of patient safety culture (12 dimensions), 7 steps towards patient safety and 6 patient safety goals, there is a patient safety indicator data collection form, and a mechanism for conducting a patient safety culture survey. The cultural guidelines also stipulate the monitoring and evaluation of patient safety culture carried out by the quality and patient safety committee. Monitoring of 6 patient safety goals is carried out every day using quality indicators. Data collection is carried out by officers who collect data on the quality of the unit recapitulated every month. Analysis of the 6 patient safety goals was carried out every 3 months.

The results of the FGD with participants of service doctors, midwives, PMKP secretary nurses, the quality sub-committee, the patient safety sub-committee, and the risk management sub-committee, obtained the following results; after the 2019 accreditation assessment PMKP activities, including the 2020 patient safety culture survey, the results showed that it was still low and did not reach the target, routine PMKP team meetings, reporting from the PMKP committee every month, reporting patient safety incidents were analyzed. The document and policy review has not been carried out but there are additional service procedures, namely SOP (standard operating procedures) for the prevention and control of infection (Pencegahan dan pengendalian Infeksi/PPI) and SOP for the use of personal protective equipment (Alat Pelindung Diri/APD).

With the Covid-19 pandemic, not all hospital visitors are obedient to wash hands with soap (Cuci Tangan Pakai Sabun/CTPS) and wear masks.

In-depth interviews with the head of the PMKP committee, it was concluded that the reporting of patient safety incidents by nurses and midwives was still low. Efforts have been made to upgrade with internal training, including PMKP training, patient safety culture surveys have been carried out, but incident reporting is still low, the causes include health workers who are afraid of being transferred if they make mistakes in patient handling, there is still a blaming culture at RSI, at the implementing unit level understanding of quality culture and patient safety and risk management is lacking. The chairman of the PMKP committee in the meeting suggested how to build a system so that rewards are made (not only punishment). So far, if there is an error, the staff is moved, but when someone is diligent they have not been given a reward. The reward system has been proposed by the head of the PMKP committee, then regulations for assessing and rewarding outstanding employees and units have been made and guidelines for assessing the performance of hospitals / work units have been made. But at the middle level, the management does not yet understand the measurement and its application so that the measurement is not optimal yet.

Currently, the employee performance appraisal guideline is being prepared using the employee performance target (SKP) as the basis, the objective is to assess the employee's achievement. In employee appraisal, incident reporting has not been included in the employee appraisal items, but it is still in the review process. Quality indicators are in the process of being included in employee performance appraisals in hopes of enhancing patient safety culture.

4.3 Attitude of nurses

The awareness / attitude of nurses and midwives in implementing a quality culture has been formed, but the application in daily care for patients has not been optimal. The Covid-19 pandemic caused several PMKP team meetings and training training related to quality culture and patient safety as well as hospital accreditation activities to be postponed until an undetermined time limit caused a decrease in the attitude of health workers in a culture of quality and patient safety. The hospital's unpreparedness in dealing with the Covid-19 pandemic in terms of the availability of PPE, the amount of personal protective equipment (Alat Pelindung Diri/APD) and the availability of other supporting facilities and infrastructure has resulted in the implementation of patient safety culture in 2020 not being implemented optimally. From the results of the FGD, indeph interviews were conducted with several key figures. Interviews with nurses and senior midwives found that there was still a feeling of fear and shame when reporting Patient Safety incidents, this attitude of reporting required encouragement and motivation (not yet embedded in officers about the importance of Patient Safety). Workload sometimes causes a lack of attention to Patient Safety.

So far, most safety incident reports have come from pharmaceutical installations. Service behavior (nurses, midwives) is still a cause for concern, because by questioning things that are not included in the quality indicator, energy is used up to fix things that are not included in the quality indicators so that they do not focus on improving quality indicators. The reason is a lack of understanding of patient safety culture, Concerning with low reporting of patient safety incidents, the support from the directors and management for the quality system was excellent. So far, the Patient‘s Quality

and Safety Improvement Team Leader has a strong commitment to the implementation of PMKP in Islamic Hospital of Banjarnegara.

4.4 Leadership support

The RSI Director has a visionary and innovative mindset for the development of the Banjarnegara Islamic Hospital. The results of the in-depth interview with the Director of the RSI may be concluded that there was support and attention from the RSI management for all hospital programs including the PMKP Program.

4.5 Work environment

The working environment conditions at RSI Banjarnegara are very conducive to support the implementation of a patient safety culture. Various facilities and infrastructure have been provided to increase the comfort and safety of patients and employees who work there.

4.6 Nurse job satisfaction

The high leadership support from the manager gives encouragement to nurses and all staffs at RSI Banjarnegara. Unfortunately, the high morale of nurses and will be strengthened by training to improve their abilities has been disrupted by the Covid-19 pandemic.

5. Conclusion

a. Patient safety culture at Islamic Hospital of Banjarnegara (RSI Banjarnegara) already exists but is still low (not on target).
b. Incident reporting is still low.
c. The Patient‘s Quality and Safety Improvement (Peningkatan Mutu dan Keselamatan Pasien/PMKP) system is still working; regulations that support the culture of Patient Safety are already good.
d. The commitment of the Patient‘s Quality and Safety Improvement committee chairman, directors and managers to Patient Safety is already good, but it is still inconsistent because there is still punishment to move employees if they make mistakes.
e. Several things that affect: there is a lack of understanding of Patient Safety at the executive / unit level, the existence of a blaming culture (punishmen), no reward for those who have implemented the Patient Safety culture, regulations regarding the certainty of quality indicators are unclear, workload, the covid pandemic that causes the uncertainty of the accreditation assessment, lack of facilities and infrastructure, personal protective equipment (PPE), and the PMKP meetings / training not running have caused a decline in the culture of Patient Safety .

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